HEALTH SERVICES AND DEVELOPMENT AGENCY MEETING
NOVEMBER 19, 2014
APPLICATION SUMMARY

NAME OF PROJECT:	Metro Knoxville HMA, d/b/a Tennova Healthcare-Physicians Regional Medical Center
PROJECT NUMBER:	CN1408-034
ADDRESS:	Unaddressed Site at the intersection of Middlebrook Pike and Old Weisgarber Road Knoxville (Knox County), Tennessee 37909
LEGAL OWNER:	Knoxville HMA Holdings, LLC 930 Emerald Avenue, POB Suite 813 Knoxville (Knox County), Tennessee 37919
OPERATING ENTITY:	Community Health Systems Professional Services Corporation 4000 Meridian Boulevard Franklin (Williamson County), Tennessee 37067
CONTACT PERSON:	Melanie B. Burgess (865) 647-5604
DATE FILED:	August 13, 2014
PROJECT COST:	$6,454,796
FINANCING:	Cash Reserves
PURPOSE OF REVIEW:	Relocation and replacement of an existing 25 bed skilled nursing home

DESCRIPTION:

Metro Knoxville HMA, LLC d/b/a/ Tennova Healthcare-Physicians Regional Medical Center, CN1408-034 proposes to replace and relocate a separately licensed 25 bed skilled nursing unit currently located at Physicians Regional Medical Center (PRMC) on the 3rd floor of the Annunication wing at 900 E. Oak Hill Avenue, Knoxville (Knox County), to the 4th floor of the new proposed location of Physician's Regional Medical Center located

at the intersection of Middlebrook Pike and Old Weisgarber Road, Knoxville (Knox County), Tennessee.

The project does not involve the addition of new beds, the initiation of new health care services, or acquisition of major medical equipment. At completion, the skilled nursing unit will remain licensed for 25 beds. The estimated project cost is $6,454,796.

Note to Agency Members: A separate Certificate of Need application is being filed for the partial relocation and replacement of Physician's Regional Medical Center (CN1408-033). This proposed project (CN1408-034) would be located in a 19,560 SF unit that will be constructed as part of the proposed partial replacement hospital. The Metro Knoxville HMA, LLC d/b/a/ Tennova Healthcare-Physicians Regional Medical Center, (CN1408-033) project includes constructing a new 556,083 square foot hospital to replace the existing 917,235 square foot facility and the relocation of 272 of the 401 licensed beds and 24 operating/procedure rooms. If approved, 38 adult and geriatric psychiatric beds and 91 medical/surgical licensed beds are planned to remain at the existing PRMC Oak Hill campus. The following services will be relocated to the new site: acute care services, obstetrical services, critical care services, Level II B neonatal nursery services, cardiac catheterization services, extra-corporal shock wave lithotripsy services, open heart, inpatient rehabilitation services, and radiation therapy services. Major medical equipment that will be relocated includes 1 Positron Emission Tomography (PET) Unit, 1 linear accelerator and 2 Magnetic Resonance Imaging (MRI) units. The estimated project cost is $303,545,204.00.

SERVICE SPECIFIC CRITERIA AND STANDARD REVIEW
CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

The following apply:

For relocation or replacement of an existing licensed health care institution:

a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

Hospital

The original hospital was built in 1930 and expanded 12 times between 1930 and 1999. PRMC states renovation of the existing hospital will not resolve the following critical issues that face the hospital in its current location:

1) Efficiency and accessibility

- *The topography of the current site, as well as compressed acreage and a lack of a cohesive master plan in the early decades of the hospital resulted in an existing campus consisting of 1.5 million square feet of office building and garages spread over 13 buildings.*

- *The long distances and multiple elevators are challenging for sick patients, confusing for family members, and inefficient for staff.*
- *New payment models do not support a hospital with a large physical footprint and less efficient flow.*

2) Infrastructure Issues

- *The existing 13 buildings share an electrical, ventilation, and air conditioning (HVAC) infrastructure making it difficult and expensive to renovate.*
- *The hospital is served by 3 chillers, ranging in age from 17 to 37 years, and 2 boilers, 1 installed in 1955 and 1 in 1977.*

3) Medical Staff Demand

- *Many physicians have moved their offices away from PRMC because of the age and inaccessibility of the campus, as well as patient feedback.*

Note to Agency members: The Dowell Springs Business Park, a 120 acre campus commercial/medical complex, is located near the proposed replacement hospital site. One of the largest tenants of the Dowell Springs Business Park is Provision. The Provision Health Alliance campus at Dowell Springs is a comprehensive clinical outpatient healthcare facility that consists of multiple physician practice groups, comprehensive diagnostic imaging, advanced chemotherapy and radiation therapy, a wellness center, physical therapy, nuclear pharmacy, and clinical trials and research capabilities. Source: http://provisionproton.com/about-us/your-campus

The applicant provided the following costs to renovate the existing facility:

Infrastructure Upgrades	*$80,000,000*
Five Years Maintenance	*$75,000,000*
Equipment Replacement	*$80,000,000*
Renovation for Orthopedics	*$15,000,000*
Renovation for Cardiology	*$12,000,000*
5 Year Capital Investment Total	***$262,000,000***

Skilled Nursing Unit

- *The current skilled nursing unit of the hospital is located in the Annunciation Wing of the hospital which was built in 1966 prior to the Americans with Disabilities Act (ADA).*
- *The patient rooms would require extensive upgrades and reconfiguration to meet current ADA requirements.*
- *Each bathroom has a toilet and sink, but the shower is a common shower located in the hallway. There are a few patient rooms that have separate showers but are too small to accommodate wheelchairs and walkers.*

The applicant chose to construct a new hospital to avoid the costs of investing in an existing building that would still be inefficient after renovation. The estimated hospital renovation cost is $262,000,000 while the total project cost to construct a partial replacement hospital is $303,000,000. The proposed 25 bed skilled nursing unit totals 19,650 SF with a proposed construction cost of $5,895,000.

It appears that this criterion has been met.

b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

The applicant projects a slight -0.5% decrease in nursing home admissions from 771 in 2013, to 767 in Year Two (2018) of the proposed project. Occupancy will increase from 72.1% in 2012 on 6,767 days, to 83.6% in Year 2019 on 7,630 days.

It appears that this criterion has been met.

Staff Summary

The following information is a summary of the original application and all supplemental responses. Any staff comments or notes, if applicable, will be in bold italics.

Physicians Regional Medical Center is a 401 bed hospital operating as the main campus location of Metro Knoxville HMA, LLC, dba Tennova Healthcare. The 25 bed skilled nursing unit located within the hospital operates under a separate license and Medicare number, but is considered part of Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare-Physicians Regional Medical Center.

Tennova Healthcare (formerly Mercy Health Partners) operates Physicians Regional Medical Center (Physicians Regional), North Knoxville Medical Center, and Turkey Creek Medical Center (Turkey Creek) in Knox County under one hospital license and Medicare provider number. As a whole, Tennova Healthcare is licensed for 610 beds and staffs 447 of those beds over the three facilities. Tennova also formerly operated the 293 bed Riverside campus as a satellite but those beds were surrendered in 2013.

An overview of the project is provided on pages 6-8 of the original application.

Please refer to the Square Footage and Cost per Square Footage Chart on page 10 of the original application for additional information.

Need

- The original hospital was built in 1930 and has experienced 12 expansions and is now aged and obsolete, making renovations and additions cost prohibitive.
- PRMC's orthopedic program needs post-acute care such as skilled nursing that is efficient, cost-effective, and has high patient satisfaction.
- A skilled nursing unit within a hospital enables the unit to accept patients with greater medical needs than many nursing homes can provide.
- The current facility is not best suited for patient recovery or satisfaction.
- Patients in the current skilled nursing unit must use a common shower located in the hallway.
- The current therapy gym for skilled nursing patients is too small and is located 3 floors away from the beds.
- The service area senior adult population is expected to grow by 3.4% in the next 5 years.

Ownership

Metro Knoxville HMA, d/b/a Tennova Healthcare-Physicians Regional Medical Center is owned by Knoxville HMA Holdings, LLC, which is a wholly owned

indirect subsidiary of CHS/Community Health Systems, Inc. In addition to the three inpatient campuses operating under one license (Physicians Regional Medical Center, North Knoxville Medical Center, and Turkey Creek Medical Center), Tennova also owns Jefferson Memorial Hospital (Jefferson County), LaFollette Medical Center (Campbell County), Newport Medical Center (Cocke County), and Lakeway Regional Hospital (Hamblen County). Ownership information is provided in Attachment B.I. Project Description.3.

Note to Agency members: In the application, Tennova Healthcare-Physicians Regional Medical Center, CN1408-033, the applicant acknowledges the existence of a $98 million dollar civil settlement between Community Health Systems, Inc. (CHS) and the federal government (Medicare and Tricare) and state agencies from an investigation that began in the spring of 2011. According to the applicant, the following is a summary of the civil settlement:

- ***The government alleged hospitals affiliated with Community Health Systems, Inc. improperly billed for treatment provided to patients over the age of 65.***
- ***Patients were admitted as inpatients by their treating physicians and cared for in an inpatient setting and submitted bills for that level of care.***
- ***The government subsequently asserted that the patients should have been classified as "observation" patients and billed as such.***
- ***In reaching the settlement, CHS worked cooperatively with the government, did not admit to any improper conduct, and sought to avoid the uncertainty of litigation.***
- ***The settlement and releases were from the non-HMA acquired facilities, so Physicians Regional Medical Center (PRMC) was not part of the settlement, however, all affiliates of CHS are covered by the Corporate Integrity agreement entered into in connection with the settlement between CHS and the United States Department of Human Services, Office of Inspector General.***

Facility Information

- The new partial replacement hospital will consist of one primary 5 floor building on a 122 acre site. A detailed layout of each floor is included on pages 9-10 of the original application.
- The proposed location of the 25 bed skilled nursing unit is 19,650 SF of space located on the 4th floor which includes therapy gym space.
- Every patient room will have an American with Disabilities Act (ADA) compliant bathroom with a shower.
- The applicant indicates the building portion of the property (80 acres) has been approved by local zoning boards.

- The back 44 acres is protected through zoning restrictions (agricultural) and a slope protection designation.
- A walking trail will be developed between the hospital and the 44 acres and will remain natural and wooded.

The 2012 Joint Annual Report indicates the PRMC nursing home was licensed and staffed for 25 beds. Licensed and staffed bed occupancy was 72.1%.

The following provides the Department of Health's definition of the two bed categories pertaining to occupancy information provided in the Joint Annual Reports:

- ***Licensed Beds - The maximum number of beds authorized by the appropriate state licensing (certifying) agency or regulated by a federal agency. This figure is broken down into adult and pediatric beds and licensed bassinets (neonatal intensive or intermediate care bassinets).***
- ***Staffed Beds - The total number of adult and pediatric beds set up, staffed and in use at the end of the reporting period. This number should be less than or equal to the number of licensed beds.***

Service Area Demographics
PRMC's declared primary service area includes the following 15 counties:

Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Roane, Scott, Sevier, and Union Counties.

- The total population of the 15 County Tennessee service area is estimated at 1,197,466 residents in calendar year (CY) 2014 increasing by approximately 4.1% to 1,246,842 residents in CY 2018.
- The overall Tennessee statewide population is projected to grow by 3.7% from 2014 to 2018.
- The latest 2014 percentage of the proposed primary service area population enrolled in the TennCare program is approximately 17.8% in the service area as compared to the statewide enrollment proportion of 18.8%.

Service Area Historical Utilization

Hospital Based Skilled Nursing Units
Service Area Historical Utilization and Overall Market Share

Facility	Licensed Beds (2012)	Patient Days			'10-'12 % Change	Occupancy		
		2010	2011	2012		2010	2011	2012
Physicians Regional Medical Center (Knox Co.)	25	7,413	6,804	6,575	-11.3%	81.2%	74.6%	72.1%
Blount Memorial Transitional Care (Blount Co.)	76	26,292	25,509	24,956	-5.1%	94.8%	92%	90%
Claiborne Co. Nursing Home (Claiborne Co.)	100	30,089	32,529	33,130	+10.0%	82.4%	89.1%	90.1%
Ft. Sanders Transitional Care (Knox Co.)	24	7,159	6,714	6,911	-3.5%	93.4%	87.6%	90.2%
Ft. Sanders Sevier Nursing Home (Sevier County)	54	16,635	15,593	16,542	-.05%	84.4%	79.1%	84%
Tennova Lafollette Health and Rehab Center (Campbell Co.)	98	26,959	33,397	34,137	+26.6%	75.4%	93.4%	95.4%
15 County Service Area	377	114,547	120,546	122,251	+6.7%	83.2%	87.6%	88.8%
Market Share								
PRMC	6.6%	6.5%	5.6%	5.4%				

Source: JARs 2010-2012

The chart above reflects the following:

- Hospital based skilled nursing days in the 15 Tennessee County service area increased 6.7% from 114,547 patient days in 2010 to 122,251 patient days in 2012.
- PRMC patient days decreased 11.3% from 7,413 in 2010 to 6,575 in 2012.
- PRMC's licensed beds represented 6.6% of all licensed hospital based skilled nursing beds in the 15 County service area with the market share of patient days decreasing from 6.5% in 2010 to 5.4% in 2012.

Applicant's Historical and Projected Utilization

Historical and projected trends for the PRMC nursing home are displayed in the table below:

Department	2010	2011	2012	2018 Year 1	2019 Year 2
Total PRMC (Nursing Home Beds)	25	25	25	25	25
Admissions	822	810	771	742	767
Average Daily Census	20.3	18.7	18.5	20.2	20.9
Patient Days	7,413	6,810	6,767	7,383	7,630
Occupancy	81.2%	74%	72.1%	80.9%	83.6%

Source: CN1408-034

- Admissions will decrease 6.7% from 822 in 2010 to 767 in Year 2 (2019) of the proposed project.
- Occupancy will increase from 81.2% in 2010 on 7,413 patient days, to 83.6% in Year 2019 on 7,630 patient days.

Project Cost

Major costs are:

- Construction Costs plus contingencies- $5,895,000 or 91.3% of total cost.
- Architectural and Engineering Fees- $347,805, or 5.4% of the total cost.
- Average total construction cost is expected to be $300.00 per square foot, which is between the median cost of $274.63/SF and 3rd quartile cost of $324.00/SF of previously approved hospital projects from 2011-2013.
- For other details on Project Cost, see the Project Cost Chart on page 34 of the original application.

Historical Data Chart

- According to the Historical Data Chart the 25 bed PRMC nursing home experienced profitable net operating results for the three most recent years reported: $1,742,725 for 2011; $3,250,060 for 2012; and $3,063,415 for 2013.
- Average Annual Net Operating Income (NOI) was favorable at approximately 53% of annual net operating revenue for the year 2013.

Projected Data Chart

- 742 nursing home admissions are projected in Year 1 and 767 nursing home admissions in Year 2.
- Net operating income less capital expenditures for the proposed project will equal $3,101,998 in Year 2018 increasing to $3,205,257 in Year 2019.

Charges

In Year One of the proposed project, the average charge per nursing home case is as follows:

Average Gross Charge
- $14,368

Average Deduction from Operating Revenue
- $6,472

Average Net Charge
- $7,896

Medicare/TennCare Payor Mix

- TennCare/Medicaid-Charges will equal $319,832 in Year One representing 3% of total gross revenue.
- Medicare/Managed Medicare- Charges will equal $5,479,783 in Year One representing 51% of total gross revenue.
- The applicant is Medicaid certified, and contracts with all TennCare Managed Care Organizations that serves the region.

Financing

- The source of funding for the project is identified as a cash transfer from the applicant's parent (CHS/Community Health Systems Incorporated) to Knoxville HMA Holdings, LLC.
- An August 27, 2014 letter signed by the Chief Financial Officer of Physicians Regional Medical Center attests to CHS/Community Health Systems, Inc.'s ability to finance the project.
- In supplemental #2, a letter dated August 28, 2014 from Credit Suisse verified the availability of $740,000,000 in the event cash on hand does not cover the entire cost of the project.
- Review of the Community Health Systems Consolidated Balance Sheet ending of 12/31/13 revealed cash and cash equivalents of $373,000,000, total current assets of $3,747,963,000 and current liabilities of $2,457,483,000 for a current ratio of 1.52 to 1.0.

Note to Agency members: Current ratio is a measure of liquidity and is the ratio of current assets to current liabilities which measures the ability of an entity to cover its current liabilities with its existing current assets. A ratio of 1:1 would be required to have the minimum amount of assets needed to cover current liabilities.

Staffing

The applicant's current and projected direct patient care staffing will remain unchanged at 20 FTE's. The applicant's proposed direct patient care staffing includes the following:

- 8 FTE Registered Nurses, and
- 5 LPNs, and
- 7.0 Certified Nursing Assistants

Licensure/Accreditation
PRMC is licensed by the Tennessee Department of Health. A copy of the most recent annual survey completed on November 12-14, 2013 is located in Attachment C. Orderly Development.7.d.

PRMC's 25 bed skilled nursing home is not accredited by The Joint Commission.

Public Hearing
Tennessee Health Services and Planning Act, 68-11-1608 (b), states "upon request by interested parties or at the direction of the executive director, the staff of the agency shall conduct a fact-finding public hearing on the application in the area in which the project is to be located". A public hearing was requested for this application. A public hearing was held on October 27, 2014 in Knoxville (Knox County), Tennessee. A public hearing summary will be included in this application packet.

Corporate documentation, real estate deed information, performance improvement plan, utilization review plan, and patient bill of rights are on file at the Agency office and will be available at the Agency meeting.

Note to Agency Members: If approved, PRMC requests an extended expiration date of four years, which is one year beyond the normal expiration date for hospital projects. The Project Completion Chart on page 64 of the original application indicates the initiation of service for the proposed project is projected to occur in April 2018.

CERTIFICATE OF NEED INFORMATION FOR THE APPLICANT

There are no other Letters of Intent, denied applications, or outstanding Certificates of Need for this applicant.

Pending Applications

Metro Knoxville HMA, LLC d/b/a Tennova Healthcare, CN1406-033, has a pending application scheduled to be heard at the November 19, 2014 Agency meeting. The proposed project is for the partial replacement and relocation of 272 of 401 beds from Physicians Regional Medical Center from 900 E. Oak Hill Avenue, Knoxville (Knox County) to a site at the intersection of Middlebrook Pike and Old Weisgarber Road across from Dowell Springs Boulevard, Knoxville

(Knox County), a distance of approximately nine (9) miles from the current facility. The estimated project cost is **$303,545,204.00.**

Note: Community Health Systems, Inc. has a financial interest in this project and the following:

Outstanding Certificates of Need

Lakeway Regional Hospital, CN1405-013A, has an outstanding Certificate of Need that will expire on October 1, 2017. The project was approved at the August 27, 2014 Agency meeting for the discontinuation of obstetrical (OB) services. The 16 OB beds will be redistributed to general medical/surgical beds. The hospital's current 135 licensed bed complement will remain unchanged. The estimated project cost **is $33,000.00.** *Project Status: The project was recently approved in August 2014.*

Dyersburg Regional Medical Center, CN1403-007A, has an outstanding Certificate of Need that will expire on September 1, 2017. The project was approved at the July 23, 2014 Agency meeting for the expansion of Diagnostic Cardiac Catheterization Services, currently limited to diagnostic procedures, to include interventional (therapeutic) cardiac catheterization procedures at Dyersburg Regional Medical Center, Dyersburg (Dyer County), Tennessee. The estimated project cost is **$367,763.** *Project Status: The project was recently approved in July 2014.*

Metro Knoxville, HMA, LLC d/b/a Tennova Healthcare-North Knoxville Medical Center, CN1211-056A, has an outstanding Certificate of Need that will expire on April 1, 2016. The CON was approved at the February 27, 2013 Agency meeting for the initiation of diagnostic cardiac catheterization services. The project involves construction and equipping of shell space within the hospital to serve as a dual cardiac catheterization/vascular lab, support areas for the lab, expanded waiting room, and additional pre-operative and post-operative space. The estimated project cost is **$4,377,421.00.** *Project Status: Per update provided on 7/30/14 by a representative for CHS, service is scheduled to begin in late 2014.*

HMA Fentress County Hospital, LLC d/b/a Jamestown Regional Medical Center, CN1211-055, has an outstanding Certificate of Need that will expire on April 1, 2016. The CON was approved at the February 27, 2013 Agency meeting for the conversion of 6 existing acute care hospital beds to swing beds located at 436 Central Avenue West, Jamestown (Fentress County). The estimated project cost is **$30,677.00.** *Project Status: Project Status: Per update provided on 7/30/14 by a representative for CHS, service is scheduled to begin in late 2014.*

Lebanon HMA, d/b/a University Medical Center, CN1210-051A, has an outstanding Certificate of Need that will expire March 1, 2016. The CON was approved at the January 23, 2013 agency meeting for the initiation of linear accelerator services and acquisition of existing major medical equipment from Southeast Cancer Network, Inc. The estimated project cost is **$4,844,035.00.** Project Status: *Per update provided on 11/4/14 by a representative for CHS, University Medical Center now operates the Radiation Oncology Center. Southeast Cancer Network continues to provide treatment planning services. UMC is working to purchase upgraded linear accelerator equipment and are exploring a potential management arrangement for the Radiation Oncology Center.*

North Knoxville Medical Center f/k/a Mercy Medical Center-North, CN1106-019A, has an outstanding Certificate of Need that will expire on 12/1/2014. The CON was approved at the October 26, 2011 Agency meeting for acquisition of a second linear accelerator for its radiation therapy department located on Mercy Medical Center-North campus located at 7551 Dannaher Way, Powell (Knox County), Tennessee 37849. The estimated project cost is **$4,694,671.** *Project Status Update: Tennova Healthcare filed a one year extension request that will be heard at the Agency's November 2014 meeting.*

CERTIFICATE OF NEED INFORMATION FOR OTHER SERVICE AREA FACILITIES:

There are no other Letters of Intent or denied applications for other health care organizations in the service area proposing this type of service.

Pending Applications

University of Tennessee Medical Center, CN1409-042, has a pending application scheduled to be heard at the December 17, 2014 Agency meeting. The proposed project is for the modification of a hospital requiring capital expenditure greater than $5,000,000 and the addition of 44 licensed beds. The project includes renovation and the new construction total approximately 55,302 SF in the following areas: 1) The expansion and renovation of the Neonatal Intensive Care Unit (NICU) consisting of approximately 9,758 SF of new construction and renovation of 15,432 SF., 2) The addition of approximately 16,850 SF of new space and renovation of approximately 1,262 SF of existing space, which will house a new addition to the intensive care unit (ICU); and 3) The renovation of approximately 12,000 SF of existing space to convert it from non-inpatient care space to inpatient rooms. Twenty-eight of the forty-four beds are anticipated to be allocated as medical /surgical beds and 16 as ICU beds. The project will increase the licensed bed capacity from 581 to 625. The estimated project cost is **$26,292,001.00.**

Outstanding Certificates of Need

University of Tennessee Medical Center, CN0912-056A, has an outstanding Certificate of Need which will expire on May 1, 2015. It was approved at the March 24, 2010 Agency meeting for the interior build out of approximately 47,428 SF of shelled-in space, being floors 3 and 4 of the hospital wing authorized under CN0801-004A. The built-out space will house patient rooms for cardiology and cardiothoracic patients, and is located on the main campus of UTMC at 1924 Alcoa Highway, Knoxville (Knox County), TN. There will be no change from the UTMC's current licensed bed complement of 581 beds. The estimated cost of the project is **$13,941,818.00.** *Project Status Report: The project was modified on March 27, 2013 with the expiration date extended to May 1, 2015.*

University of Tennessee Medical Center, CN1002-022A, has an outstanding Certificate of Need that will expire on April 1, 2015. The CON was approved at the August 25, 2010 Agency meeting for the construction of an addition to the existing surgery facilities consisting of approximately 28,000 SF of space to house 13 new operating rooms. The project also includes the renovation of existing space in the surgical facilities and the addition of a new endovascular suite. The estimated project cost is **$18,432,272.00.** *Project Status: Project Status: The project was modified on March 27, 2013 and granted an 18 month extension date from October 1, 2013 to April 1, 2015.*

PLEASE REFER TO THE REPORT BY THE DEPARTMENT OF HEALTH, DIVISION OF HEALTH STATISTICS, FOR A DETAILED ANALYSIS OF THE STATUTORY CRITERIA OF NEED, ECONOMIC FEASIBILITY, AND CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE IN THE AREA FOR THIS PROJECT. THAT REPORT IS ATTACHED TO THIS SUMMARY IMMEDIATELY FOLLOWING THE COLOR DIVIDER PAGE.

PME
(10/30/2014)

LETTER OF INTENT

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the **Knoxville News Sentinel** which is a newspaper
(Name of Newspaper)
of general circulation in **Knox County**, Tennessee, on or before **August 8, 2014**, for one day.
(County) (Month / day)(Year)

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: **Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – Physicians Regional Medical Center, Hospital**
(Name of Applicant) (Facility Type-Existing)

owned by: **Knoxville HMA Holdings, LLC,** with an ownership type of **Limited Liability Corporation** and to be managed by: **Community Health Systems Professional Services Corporation** intends to file an application for a Certificate of Need

for: **relocating the Tennova Healthcare – Physicians Regional Medical Center 25-bed nursing home from the existing campus of Physicians Regional Medical Center, currently located at 900 E. Oak Hill Avenue, Knoxville, TN 37917, to the currently unaddressed site of a proposed replacement hospital at the intersection of Middlebrook Pike and Old Weisgarber Road, across from Dowell Springs Boulevard in Knoxville. A separate Certificate of Need application is being filed for the replacement and relocation of the hospital. The nursing home beds would be located in a unit that will be constructed as part of the proposed replacement hospital, on Middlebrook Pike at its intersection with Dowell Springs Boulevard in Knoxville. No new beds or new healthcare services are proposed in this project. The anticipated total cost of the project is $6,454,796.**

The anticipated date of filing the application is: **August 13, 2014**

The contact person for this project is **Melanie Burgess** (Contact Name) **Asst. Vice President** (Title)

who may be reached at: **Tennova Healthcare – Physicians Regional Medical Center** (Company Name)
930 Emerald Ave., POB Suite 813 (Address)

Knoxville (City) **Tennessee** (State) **37919** (Zip Code) **865 / 647-5604** (Area Code / Phone Number)

Melanie B Burg
(Signature)

August 6, 2014 (Date) **melanie.burgess@hma.com** (E-mail Address)

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

COPY-

-Application

Tennova Healthcare-Nursing Home CN1408-034

CERTIFICATE OF NEED APPLICATION

For the

RELOCATION OF SKILLED NURSING HOME BEDS TO A REPLACEMENT FACILITY

Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – Physicians Regional Medical Center

August 13, 2014

Contact:
Melanie B. Burgess
Vice President of Development
Tennova Healthcare
200 E. Blount Avenue, Suite 600
Knoxville, TN 37920

SECTION A:

APPLICANT PROFILE

1. ***Name of Facility, Agency, or Institution***			
Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – Physicians Regional Medical Center			
Name			
Currently Unaddressed Site at the intersection of Middlebrook Pike and Old Weisgarber Road		**Knox**	
Street or Route		*County*	
Knoxville	**TN**	**37909**	
City	*State*	*Zip Code*	
2. ***Contact Person Available for Responses to Questions***			
Melanie B. Burgess	**Vice President of Development**		
Name	*Title*		
Tennova Healthcare	**melanie.burgess@hma.com**		
Company Name	*Email address*		
930 Emerald Ave, POB Suite 813	**Knoxville**	**TN**	**37917**
Street or Route	*City*	*State*	*Zip Code*
Employee	**865-647-5604**	**865-647-5630**	
Association with Owner	*Phone Number*	*Fax Number*	
3. ***Owner of the Facility, Agency or Institution***			
Knoxville HMA Holdings, LLC		**865-647-5600**	
Name		*Phone Number*	
930 Emerald Ave., POB Suite 813		**Knox**	
Street or Route		*County*	
Knoxville	**TN**	**37919**	
City	*State*	*Zip Code*	

4. ***Type of Ownership of Control (Check One)***

A.	Sole Proprietorship		F.	Government (State of TN or Political Subdivision)	
B.	Partnership				
C.	Limited Partnership		G.	Joint Venture	
D.	Corporation (For Profit)		H.	Limited Liability Company	X
E.	Corporation (Not-for-Profit)		I.	Other (Specify)_____	

PUT ALL ATTACHMENTS AT THE BACK OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

5. ***Name of Management/Operating Entity (If Applicable)***		
Community Health Systems Professional Services Corporation		
Name		*Phone Number*
4000 Meridian Boulevard	**Davidson**	
Street or Route	*County*	
Nashville	**TN**	**37067**
City	*State*	*Zip Code*

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

6. ***Legal Interest in the Site of the Institution (Check One)***

A.	Ownership	X	D.	Option to Lease	
B.	Option to Purchase		E.	Other (Specify) _____	
C.	Lease of _____ Years				

PUT ALL ATTACHMENTS AT THE END OF THE APPLICATION IN ORDER AND REFERENCE THE APPLICABLE ITEM NUMBER ON ALL ATTACHMENTS.

7. ***Type of Institution (Check as appropriate--more than one response may apply)***

A.	Hospital (Specify) _____		I.	Nursing Home	X
B.	Ambulatory Surgical Treatment Center (ASTC), Multi-Specialty		J.	Outpatient Diagnostic Center	
C.	ASTC, Single Specialty		K.	Recuperation Center	
D.	Home Health Agency		L.	Rehabilitation Facility	
E.	Hospice		M.	Residential Hospice	
F.	Mental Health Hospital		N.	Non-Residential Methadone Facility	
G.	Mental Health Residential Treatment Facility		O.	Birthing Center	
H.	Mental Retardation Institutional Habilitation Facility (ICF/MR)		P.	Other Outpatient Facility (Specify)_____	
			Q.	Other (Specify) _____	

8. Purpose of Review *(Check) as appropriate--more than one response may apply)*

A.	New Institution		G.	Change in Bed Complement *[Please note the type of change by underlining the appropriate response: Increase, **Decrease**, Designation, Distribution, Conversion, Relocation]*	
B.	Replacement/Existing Facility	X			
C.	Modification/Existing Facility				
D.	Initiation of Health Care Service as defined in TCA §68-11-1607(4) (Specify)_____		H.	Change of Location	X
E.	Discontinuance of OB Services		I.	Other (Specify)_____	
F.	Acquisition of Equipment				

9. Bed Complement Data**
Please indicate current and proposed distribution and certification of facility beds.

		Current Beds		Staffed Beds	Beds Proposed	TOTAL Beds at Completion
		Licensed	*CON			
A.	Medical					
B.	Surgical					
C.	Long-Term Care Hospital					
D.	Obstetrical					
E.	ICU/CCU					
F.	Neonatal					
G.	Pediatric					
H.	Adult Psychiatric					
I.	Geriatric Psychiatric					
J.	Child/Adolescent Psychiatric					
K.	Rehabilitation					
L.	Nursing Facility (non-Medicaid Certified)					
M.	Nursing Facility Level 1 (Medicaid only)					
N.	Nursing Facility Level 2 (Medicare only)					
O.	Nursing Facility Level 2 (dually certified Medicaid/Medicare)	25		19	25	25
P.	ICF/MR					
Q.	Adult Chemical Dependency					
R.	Child and Adolescent Chemical Dependency					
S.	Swing Beds					
T.	Mental Health Residential Treatment					
U.	Residential Hospice					
	TOTAL *CON-Beds approved but not yet in service	25		19	25	25

10. Medicare Provider Number **44-5360**
Certification Type **Nursing Home**

11. Medicaid Provider Number **44-5360**
Certification Type **Nursing Home**

12. If this is a new facility, will certification be sought for Medicare and/or Medicaid?

Not applicable.

13. *Identify all TennCare Managed Care Organizations/Behavioral Health Organizations (MCOs/BHOs) operating in the proposed service area.* Will this project involve the treatment of TennCare participants? Yes **If the response to this item is yes, please identify all MCOs/BHOs with which the applicant has contracted *or plans to contract.***

The TennCare MCOs/BHOs operating in the proposed service area are:

- Blue Cross Blue Care / TennCare Select
- Americhoice

The applicant contracts through master provider agreements with each TennCare MCO/BHO operating in the service area.

- Blue Cross BlueCare / TennCare Select utilizing ValueOptions (MCO). Tennova Healthcare – Physicians Regional Medical Center is listed as a provider with ValueOptions.
- Americhoice TennCare utilizes United Behavioral Health (MCO). Tennova Healthcare – Physicians Regional Medical Center is listed as a provider with United Behavioral Health.

There is no intent to alter our participation in these plans.

Discuss any out-of-network relationships in place with MCOs/BHOs in the area.

The applicant is in network with all TennCare MCOs/BHOs in the area.

NOTE: ***Section B*** is intended to give the applicant an opportunity to describe the project and to discuss the need that the applicant sees for the project. ***Section C*** addresses how the project relates to the Certificate of Need criteria of Need, Economic Feasibility, and the Contribution to the Orderly Development of Health Care. **Discussions on how the application relates to the criteria should not take place in this section unless otherwise specified.**

SECTION B: PROJECT DESCRIPTION

Please answer all questions on 8 1/2" x 11" white paper, clearly typed and spaced, identified correctly and in the correct sequence. In answering, please type the question and the response. All exhibits and tables must be attached to the end of the application in correct sequence identifying the questions(s) to which they refer. If a particular question does not apply to your project, indicate "Not Applicable (NA)" after that question.

I.	**Provide a brief executive summary of the project not to exceed two pages. Topics to be included in the executive summary are a brief description of proposed services and equipment, ownership structure, service area, need, existing resources, project cost, funding, financial feasibility and staffing.**

Project Description

Metro Knoxville HMA, LLC, hereinafter referred to as "Hospital", is a three campus hospital operating under a single license and provider number. The main campus of the Hospital is Tennova Healthcare – Physicians Regional Medical Center ("PRMC"), an acute care, 401 bed, 917,235 square foot, tertiary medical center located at 900 E. Oak Hill Avenue, Knoxville, Tennessee. The Hospital has two satellite locations, North Knoxville Medical Center and Turkey Creek Medical Center. In addition to the 401 acute care beds located on PRMC's campus, the facility also houses 25 skilled nursing/nursing home beds, which are under a separate license. This application is for the relocation of those 25 skilled nursing beds to a proposed replacement hospital for PRMC.

The Hospital proposes to construct a replacement facility for PRMC on approximately 110 acres on Middlebrook Pike in Knoxville, nine miles from its current location and approximately one mile from what is now the population center of Knox County, accessible to its entire 15-county service area. For maps showing the proposed location, see attachment B.I.Project Description.1. The Hospital currently holds an option on the property. The option contract is attached as attachment B.I.Project Description.2. The existing facility was built and put into service in 1930 and was expanded twelve times between 1930 and 1999. As a result of the facility's age, operational inefficiencies, accessibility issues for patients, and infrastructure challenges, significant facility upgrades or additions are not financially feasible nor are they an acceptable option for the hospital's medical staff. The intent of the proposed project is to reconstruct PRMC in such a way as to significantly improve its operational efficiency, improve the patient experience through easier access both to the campus as well as within the hospital itself, and to create a facility that is financially sustainable and meets the future needs of the region, the medical staff, and the health system. In this application, PRMC proposes to relocate the 25 skilled nursing beds to the replacement hospital.

Proposed Services and Equipment

The overall proposal is to move all acute care services and some sub-acute services currently being provided at PRMC to the Middlebrook Pike campus, including Medical/Surgical beds, Surgical services, Women's Health services, Level IIB Nursery services, Intensive Care services, Inpatient Rehabilitation services, and the Transitional Care/Skilled Nursing unit. Because the Skilled Nursing unit is separately licensed, that unit is addressed in this separate Certificate of Need application. A Certificate of Need application is being submitted simultaneously for the replacement hospital project.

This application does not involve the initiation of new services, an increase in licensed bed capacity, or the acquisition of major medical equipment. This application simply proposes to relocate the existing skilled nursing beds to the replacement hospital campus, if that Certificate of Need application is approved.

Ownership Structure

The site of service for this project is Physicians Regional Medical Center, which is the main location of Metro Knoxville HMA, LLC. In metro Knoxville, the Hospital provides inpatient care on three campuses, Physicians Regional Medical Center, North Knoxville Medical Center and Turkey Creek Medical Center. Those three campuses operate under a single hospital license and Medicare provider number. The skilled

nursing beds operate under a separate license and Medicare Provider number, but are part of Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – Physicians Regional Medical Center.

Metro Knoxville HMA, LLC is a wholly owned indirect subsidiary of CHS/Community Health Systems, Inc., with corporate offices in Franklin, Tennessee. Please see the attached ownership listing, attachment B.I.Project Description.3.

Service Area

The service area for this project consists of the following 15 counties in Tennessee: Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Knox, Loudon, Monroe, Roane, Scott, Sevier, and Union. Residents of these counties account for approximately 95% of the skilled nursing patients. A map of the service area is included as attachment B.I.Project Description.4. It should be noted that this project is not intended to alter the existing service area.

Need

PRMC is a busy, tertiary medical center located off I-275 on the northern side of Knoxville, in an area of Knox County that was vibrant when the facility was built in 1930. In 2013, PRMC admitted 14,876 patients resulting in 70,887 patient days, with an average acute length of stay of 4.77 and average daily census of 194.

The main proposed project, outlined in a separate application, is to replace and relocate Physicians Regional Medical Center. Founded in 1930 as St. Mary's Hospital, the facility has had twelve expansions over seven decades, and now consists of 917,235 square feet. Much of the support infrastructure is aged and obsolete, making major renovations or additions cost prohibitive. The layout of the hospital is highly inefficient, as well as difficult for patients and their families to navigate. The physical layout, access, and appearance of the current physical plant are becoming increasingly, if not already, obsolete. The distance between key departments impairs efficient patient flow and staff productivity.

As part of the physical facility that is housed on the existing PRMC campus, the skilled nursing beds operate with the same limitations and inefficiencies as the rest of the hospital building. A facility challenge that is particular to the skilled nursing unit is a common shower located on the hall. Private showers are not available to patients within the skilled nursing units. In addition, the current therapy gym for skilled nursing patients is too small and is located three floors away from the beds.

The availability of skilled nursing beds is crucial for patients who are require additional care but no longer qualify for an acute care stay. In addition, one of PRMC's key service lines is Orthopedics. PRMC is a Marshall-Steele Premier Site for Joint Replacements, as well as a Blue Cross Blue Shield Distinction Center + for Hip and Knee Replacements. With the large volumes of orthopedic surgical cases done in the hospital and the post-acute needs of this patient population, skilled nursing beds are a critical element in the continuum of care offered at PRMC.

Project Cost

The total estimated cost of the proposed project is $6,454,796, including the application fee and all associated legal, consulting, and financing costs. This includes the cost of construction, minor equipment and furnishings.

		Funding and Financial Feasibility The costs of the project will be funded through capital provided by CHS/Community Health Systems, Inc. The project is financially feasible in its first year, as shown in the Project Data Chart. Staffing While similar staffing levels are planned for this project as compared to the existing skilled nursing beds, the efficiencies gained are expected to allow nursing and support staff to focus more time on direct patient care and the fulfillment of critical job duties, minimizing the wasted time currently spent in transporting patients, equipment, food, and supplies throughout a vast and inefficient facility. Based on the projected volumes in the first year, it is expected that the unit staffing will be 21 FTEs.
II.	**Provide a detailed narrative of the project by addressing the following items as they relate to the proposal.**	
	A.	**Describe the construction, modification and/or renovation of the facility (exclusive of major medical equipment covered by T.C.A. § 68-11-1601 et seq.) including square footage, major operational areas, room configuration, etc. Applicants with hospital projects (construction cost in excess of $5 million) and other facility projects (construction cost in excess of $2 million) should complete the Square Footage and Cost per Square Footage Chart. Utilizing the attached Chart, applicants with hospital projects should complete Parts A.-E. by identifying as applicable nursing units, ancillary areas, and support areas affected by this project. Provide the location of the unit/service within the existing facility along with current square footage, where, if any, the unit/service will relocate temporarily during construction and renovation, and then the location of the unit/service with proposed square footage. The total cost per square foot should provide a breakout between new construction and renovation cost per square foot. Other facility projects need only complete Parts B.-E. Please also discuss and justify the cost per square foot for this project. If the project involves none of the above, describe the development of the proposal.** Physicians Regional Medical Center is proposing to replace the existing facility and relocate to approximately 110 acres on Middlebrook Pike, nine miles away from its current location. The existing hospital consists of 917,235 square feet of hospital space, plus another 624,265 square feet of medical office building and parking garage space on 21 acres. The skilled nursing beds are currently located in 11,354 square feet on the third floor of the Annunciation wing, which was built in 1966, as well as a skilled nursing gym of 2,614 square feet, located three levels away in the same building. In the proposed replacement hospital facility, the skilled nursing unit will consist of 25 beds in 19,650 square feet on the fourth floor, including therapy gym space.

		The replacement facility has been designed with the following key principles in mind: • Maximum operational efficiency and flexibility • Easy access and navigation for patients and family members • Design for future growth with minimum operational disruption The proposed skilled nursing unit is larger than the current unit in order to allow for a larger therapy gym, as well as to provide an ADA-compliant bathroom with a shower in every patient room. The site topography and zoning provide a natural buffer between the hospital and the neighboring homes. The back 44 acres is protected through agricultural zoning and a slope protection designation. As promised to the City of Knoxville and neighborhood groups during the local land use approval process, if the project is approved, a walking trail will be developed between the hospital and the 44 acres that will remain natural and wooded. The buildable portion of the property, totaling approximately 80 acres, has already been through the local required rezoning and Use on Review processes and has gained all necessary local approvals.
	B.	**Identify the number and type of beds increased, decreased, converted, relocated, designated, and/or redistributed by this application. Describe the reasons for change in bed allocations and describe the impact the bed change will have on the existing services.** No change in the bed complement of the skilled nursing beds is proposed. This application is simply to relocate the beds to the replacement hospital for PRMC, if that Certificate of Need application is approved.

SQUARE FOOTAGE AND COST PER SQUARE FOOTAGE CHART

A. Unit / Department	Existing Location	Existing SF	Temporary Location	Proposed Final Location	Proposed Final Square Footage			Proposed Final Cost/ SF		
					Reno-vated	New	Total	Reno-vated	New	Total
Skilled Nursing		13,968	n/a	4th floor	n/a	19,650	19,650	n/a	$ 300.00	$ 5,895,000
B. Unit/Dept GSF Sub-Total		13,968			n/a	19,650	19,650	n/a	$ 300.00	$ 5,895,000
C. Mechanical/Electrical SF		-			n/a	-	-	n/a	0	$ -
D. Circulation/Structure										
E. Total GSF		**13,968**			n/a	**19,650**	**19,650**	n/a	**300.00**	**$ 5,895,000**

	C.	**As the applicant, describe your need to provide the following health care services (if applicable to this application):** **1. Adult Psychiatric Services** **2. Alcohol and Drug Treatment for Adolescents (exceeding 28 days)** **3. Birthing Center** **4. Burn Units** **5. Cardiac Catheterization Services** **6. Child and Adolescent Psychiatric Services** **7. Extracorporeal Lithotripsy** **8. Home Health Services** **9. Hospice Services** **10. Residential Hospice** **11. ICF/MR Services** **12. Long-term Care Services** **13. Magnetic Resonance Imaging (MRI)** **14. Mental Health Residential Treatment** **15. Neonatal Intensive Care Unit** **16. Non-Residential Methadone Treatment Centers** **17. Open Heart Surgery** **18. Positron Emission Tomography** **19. Radiation Therapy/Linear Accelerator** **20. Rehabilitation Services** **21. Swing Beds** No new health services will be initiated. Because of its active orthopedics program, as well as the need to provide robust and accessible post-acute services to the Hospital's patients, there is a need to continue offering skilled nursing beds within the hospital.
	D.	**Describe the need to change location or replace an existing facility.** There is a significant need to replace PRMC's existing facility, for a number of reasons. The 84 year old facility is not sustainable in its current form. The baseline costs to replace and/or upgrade facility infrastructure, such as the electrical plant and boiler/chiller system is cost-prohibitive, estimated at $80 million. $80 million in infrastructure upgrades adds significantly to the cost of providing healthcare without improving technology, care delivery, patient flow, or appearance. If PRMC were to invest in the necessary infrastructure upgrades, adding to the building or renovating the existing buildings would only add to the facility's inherent operational inefficiencies. In addition, there is limited ability to reconfigure the facility on the site. The facility is surrounded by other development and was built on a slope. Adding to the building would exacerbate the existing efficiency issues and is more expensive on a per unit basis than a replacement facility. PRMC was built and expanded when the norm was for patients to have lengthy hospital stays. As healthcare has changed, and with the mandates of healthcare

		reform, it has become more critical that healthcare systems have the ability to provide care in the least acute setting that is appropriate for the patient. Therefore, having easy access to efficient and attractive post-acute care within the hospital itself is of great benefit to patients and families. Many of the patients who utilize hospital-based skilled nursing units require more medical management than the typical therapy-based nursing home can provide. PRMC has a medical staff consisting of approximately 450 affiliated physicians and its affiliated clinic has 87 employed physicians. The medical staff has been clear that their practices require a more competitive, patient-friendly, and efficient hospital. Physicians have "spoken with their feet" by relocating their offices away from PRMC, to places more accessible to their patient base, including several major physician groups that have placed their primary offices at Dowell Springs, across Middlebrook Pike from the proposed replacement hospital site. Active members of the medical staff have been polled and are almost unanimous in their agreement that a replacement hospital is required in order to meet the needs of their patients and their practices, and that post-acute care should continue to be offered as part of PRMC's services within that replacement hospital. As a responsible healthcare provider, largely dependent on our physicians, we must listen and be responsive to our physician partners who utilize our services to care for their patients. It is important, in order to continue the level of care that is currently being provided to PRMC's skilled nursing patients, that the skilled nursing unit be relocated along with the acute care hospital. The advantage for patients of having skilled nursing beds in the same facility with acute care services is that it enables the skilled nursing unit to care for patients other nursing homes would not accept, due to the severity of those patients' medical issues. Many nursing homes accept patients who only require therapy or who cannot live alone, but cannot take the more complex patients who require nursing care but who are no longer acutely ill enough for a continued stay in the hospital. In addition to continuing services to PRMC patients who transition from acute care stays to the skilled nursing unit, it is also important for the Hospital's orthopedic surgery patients to have easy access to post-acute care, as well as the improved coordination of care that comes from being located in a single facility.	
	E.	**Describe the acquisition of any item of major medical equipment (as defined by the Agency Rules and the Statute) which exceeds a cost of $1.5 million; and/or is a magnetic resonance imaging (MRI) scanner, positron emission tomography (PET) scanner, extracorporeal lithotripter and/or linear accelerator by responding to the following:**		
		1.	**For fixed-site major medical equipment (not replacing existing equipment):**	
			a.	**Describe the new equipment, including:**
				1. Total cost ;(As defined by Agency Rule). **2. Expected useful life;** **3. List of clinical applications to be provided; and** **4. Documentation of FDA approval.** Not applicable.

			b.	**Provide current and proposed schedules of operations.** Not applicable.
		2.	**For mobile major medical equipment:**	
			a.	**List all sites that will be served;**
			b.	**Provide current and/or proposed schedule of operations;**
			c.	**Provide the lease or contract cost**
			d.	**Provide the fair market value of the equipment; and**
			e.	**List the owner for the equipment.** Not applicable.
		3.	**Indicate applicant's legal interest in equipment (*i.e.*, purchase, lease, etc.) In the case of equipment purchase include a quote and/or proposal from an equipment vendor, or in the case of an equipment lease provide a draft lease or contract that at least includes the term of the lease and the anticipated lease payments.** Not applicable. The project does not involve the acquisition of major medical equipment. However, this proposal includes the assumption that 90% of the current minor equipment and furnishings will be replaced. This is a conservative estimate, but given the planned three year development period, it is reasonable to project that the majority of the existing equipment and furnishings will be at or near the end of their useful lives and will require replacement. Please see attachment B.II.E.3 for an inventory of furniture and equipment being purchased for the proposed project. Pricing is taken from the Hospital's contract pricing system.	
III	**(A)**	**Attach a copy of the plot plan of the site on an 8 1/2" x 11" sheet of white paper which must include:** **1. Size of site (*in acres*);** **2. Location of structure on the site; and** **3. Location of the proposed construction.** **4. Names of streets, roads or highway that cross or border the site.** ***Please note that the drawings do not need to be drawn to scale. Plot plans are required for all projects.*** The plot plan for the replacement hospital is attached as attachment B.III.(A).		
	(B)	**1. Describe the relationship of the site to public transportation routes, if any, and to any highway or major road developments in the area. Describe the accessibility of the proposed site to patients/clients.** The proposed site of PRMC's replacement hospital and the 25 skilled nursing beds addressed in this application is a 110 acre parcel at the intersection of Middlebrook Pike and Old Weisgarber Road, across from Dowell Springs Boulevard. The site is located approximately one mile from		

		the current population center of Knox County, according to the Knox County Chamber of Commerce data. It is located two turns from I-40/I-75, off the Papermill Road/Weisgarber Road exit (exit #383), which is 2 miles from the I-640 bypass, and 4 miles from I-75 North. The proposed site of PRMC's replacement hospital is located on an existing bus route provided by Knoxville Area Transit, Knoxville's public transportation authority. Located on Route 90, the "Crosstown Connector" route, the proposed site is easily accessible by bus. For a map of all bus routes, see attachment B.III.(B).a. For a map of the "Crosstown Connector" route, with the location of the proposed replacement hospital marked, see attachment B.III.(B).b. During the local land use approval process, it was agreed between PRMC and the City of Knoxville that a covered bus stop will be added to the property at Middlebrook Pike for the convenience of patients, patient family members, and hospital staff. In addition to Knoxville Area Transit, patients or family members in need of transportation may have access through Knoxville Community Action Committee (CAC) Service vans, which provide service to those patients who qualify. The campus is also served by East Tennessee HRA Public Transit (ETHRA) for patients in the service area's rural counties.
IV.		**Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc. on an 8 1/2" x 11" sheet of white paper.** **NOTE: *DO NOT SUBMIT BLUEPRINTS*. Simple line drawings should be submitted and need not be drawn to scale.** The floor plan for the skilled nursing unit is attached as attachment B.IV.
V.		**For a Home Health Agency or Hospice, identify:** **1. Existing service area by County;** **2. Proposed service area by County;** **3. A parent or primary service provider;** **4. Existing branches; and** **5. Proposed branches.** Not applicable.

SECTION C: GENERAL CRITERIA FOR CERTIFICATE OF NEED

In accordance with Tennessee Code Annotated § 68-11-1609(b), "no Certificate of Need shall be granted unless the action proposed in the application for such Certificate is necessary to provide needed health care in the area to be served, can be economically accomplished and maintained, and will contribute to the orderly development of health care." The three (3) criteria are further defined in Agency Rule 0720-4-.01. Further standards for guidance are provided in

the state health plan (Guidelines for Growth), developed pursuant to Tennessee Code Annotated §68-11-1625.

The following questions are listed according to the three (3) criteria: (I) Need, (II) Economic Feasibility, and (III) Contribution to the Orderly Development of Health Care. Please respond to each question and provide underlying assumptions, data sources, and methodologies when appropriate. *Please type each question and its response on an 8 1/2" x 11" white paper.* All exhibits and tables must be attached to the end of the application in correct sequence identifying the question(s) to which they refer. If a question does not apply to your project, indicate "Not Applicable (NA)."

QUESTIONS

Need

1.	**Describe the relationship of this proposal toward the implementation of the State Health Plan and Tennessee's Health: Guidelines for Growth.** The Five Principles to Achieving Better Health in the State Health Plan are: • Healthy Lives • Access to Care • Economic Efficiencies • Quality of Care • Healthcare Workforce This application contributes to the Five Principles, most notably: • Healthy Lives. In the State Health Plan, it is noted that Tennesseans see heart disease, stroke, and high blood pressure as having the greatest impact on the health of state residents. In this section it is also noted that health starts "where we live, work, and learn." This application is focused on providing needed post-acute healthcare services to a population in need of more care than could be received at home, in a location that is accessible to a broad range of patients from across the service area. • Access to Care. Two of the key areas identified in the State Health Plan as impacting access to care are economic access and geographical access. Through both its broad charity care policy as well as full participation in all TennCare and Medicare programs, the Hospital and PRMC strive to ensure care is provided to patients regardless of income, and will continue to do so in a new location. This application also addresses geographical access to care, or as the Health Plan says, "the distance one has to travel to receive comprehensive care." The plan directly identifies strategies that are in keeping with this project to help promote access to care, including ensuring that geography is not a barrier to critical health services. The proposed replacement hospital site is located one mile from the population center of Knox County, and is easily accessible via interstate from all parts of the service area. PRMC currently serves a 15-county service area, and that service area is not expected to change. In addition, the guidelines for nursing home beds indicate that the service area should encompass an area that is no more than a 30 minute drive from the site, which is the case in this project. • Economic Efficiencies. The State Health Plan identifies one of the key elements in providing economically efficient healthcare as "balancing competitive markets, health systems, and economic efficiencies." In order for PRMC's skilled nursing unit to continue to be a competitive provider and economically viable, it must provide skilled nursing services in a location that is significantly more operationally efficient and in a setting that is attractive to patients and to physicians. • Quality of Care. The 2012 State Health Plan update describes high-quality healthcare as care that is:

before the 2008 merger between St. Mary's Health System and Baptist Hospital of East Tennessee. Over the years, several plans have been developed to renovate the existing hospital, but renovation does not solve the hospital's critical issues:

1) Efficiency and accessibility issues. The existing campus has 1.5 million square feet including medical office buildings and parking garages and is spread over 13 buildings. The topography of the site, as well as the compressed acreage and lack of a cohesive master plan in the early decades of the hospital, drove development of buildings that are not easily navigable or reached from one another. The long distances and multiple elevators required are challenging for sick patients, confusing for family members, and inefficient for staff. While space to add another tower or patient care facility is very limited, it is possible to do on the existing site. However, additional space would only add to the efficiency and accessibility issues.

   Historic payment models were such that hospitals could afford to maintain higher levels of staffing in order to support a larger physical footprint and less efficient flow. With new payment models, downward pressure on reimbursement rates by governmental payers, and the challenges of qualifying patients for skilled nursing services, PRMC must focus resources on direct patient care and mission-critical support activities.

2. Infrastructure issues. The 13 buildings on the existing campus share electrical and HVAC infrastructure, making it very difficult and expensive to modify for renovation or additions. The entire campus is served by a single power plant with an interconnected electrical system. The hospital is served by three chillers, ranging in age from 17 to 37 years, and two boilers, one installed in 1955 and one in 1977. The estimate to upgrade and replace the hospital infrastructure, which would be required in any major renovation or addition, is $80 million. This cost contributes nothing to the improvement of health services while adding to the cost of delivering healthcare. In addition to the general facility infrastructure challenges, there are configuration issues for the skilled nursing unit that make providing care more difficult. For example, patients must be transported three floors away for therapy, and there is no space within the current unit in which to add a therapy gym.

3. Medical staff demand. The 450 members of PRMC's medical staff have overwhelmingly voiced concern that the existing hospital facility is no longer acceptable for many patients who are choosing to receive care in newer and more easily accessible environments. Because of the age and inaccessibility of the campus, as well as patient feedback, many physicians have chosen to move their offices away from PRMC.

   PRMC is home to one of the highest-rated joint replacement and orthopedic programs in the State. The providers have been requesting improved facilities for their patients for years, including an

		o Safe o Effective o Patient-centered o Timely o Efficient o Equitable This project seeks to improve safety by replacing aged and inefficient facilities and equipment with modern, state-of-the-art facilities. The project is patient-centered by ensuring convenient access for patients in every part of the service area, as well as by providing an internal environment that is more conducive to the healing process. The project is efficient in terms of improving staff efficiency. The Hospital is committed to providing care in an equitable way, providing the same level of care regardless of race, gender, ethnicity, or socioeconomic status. At PRMC there is a strong commitment to continuing to provide services that are accessible to all patients. • Healthcare Workforce. One of the stated strategies in the State Health Plan around the Healthcare Workforce is to "assure the health care workforce is trained to provide high quality and culturally competent care." If the project is approved, the existing skilled nursing staff will be transferred to the replacement hospital, ensuring that well-trained and highly competent staff members are retained and that patients receive care from experienced, dedicated nurses and support staff. In addition, improved efficiency should help ease increasing demand for nurses and other patient care staff, thus benefiting the entire market, including PRMC's competitors.
	A.	**Please provide a response to each criterion and standard in Certificate of Need categories that are applicable to the proposed project. Do not provide responses to General Criteria and Standards (pages 6-9) here.** Not applicable. No new services are being initiated.

	B.	**Applications that include a Change of Site for a health care institution, provide a response to General Criterion and Standards (4)(a-c).** The General Criterion and Standards for the relocation or replacement of an existing licensed healthcare institution are: *(a) The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.* Several options were considered before settling on the decision to build a replacement hospital. The medical staff has been requesting a replacement facility or significant upgrade for PRMC for approximately ten years, since

upgraded skilled nursing unit co-located with the orthopedic unit for post-acute care, patient-friendly educational space, and greater ease of accessibility. Over the past 10 years, various plans have been developed to attempt to meet these needs on the existing campus, but the configuration of the existing buildings and the infrastructure issues have made those plans infeasible.

As previously noted, renovation of the existing hospital will not resolve the critical issues facing the hospital in its current location. Cost estimates were developed for facility renovation. While the simple capital cost of renovation is lower than the cost to build a replacement facility, renovation also includes:

- Higher operational costs due to inefficiency (utilities, staff time)
- Lower patient and medical staff satisfaction (patient satisfaction has financial impact today through CMS' Value Based Purchasing program)
- Continued volume losses due to physician and patient dissatisfaction with the current facility

Cost to Renovate Existing Hospital ($ millions)		
Infrastructure upgrades	$	80
Five years' maintenance	$	75
Equipment replacement	$	80
Renovation for orthopedics	$	15
Renovation for cardiology	$	12
5 year capital investment	**$**	**262**

An estimated investment of $262 million to stay in a facility that would still have inherent inefficiencies for staff and accessibility issues for patients is not a wise investment, relative to investing $303 million in a facility that will enhance efficiencies and provide a positive patient and medical staff experience for decades to come. On the strict basis of initial capital costs, the costs to renovate appear lower than the costs to build a replacement hospital, but what must also be considered is the lost volume due to physicians moving procedures and hospital admissions to competitor hospitals, in response to the system not providing a replacement hospital when one was promised by previous ownership, in 2008.

More specific to the skilled nursing beds, they are located in the Annunciation wing of the hospital that was built in 1966, 48 years ago. The patient rooms were built prior to the Americans with Disabilities Act, so any refurbishment or renovation would require extensive upgrades and reconfiguration of the rooms. Each bathroom is equipped with a toilet and sink, but the shower is a central shower located on the hall. The few patient rooms that have separate showers are too small for patients utilizing wheelchairs or walkers. The facility constraints are a negative for patients and their families.

(b) The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

		As part of the analysis as to whether there exists sufficient need for the existing skilled nursing beds, there are two critical questions: • Is the existing skilled nursing unit meeting a need in the community? • Is there value in those nursing beds being inside the hospital facility? First, the skilled nursing unit at PRMC is certainly meeting a need in the community today. While volumes have declined somewhat over the past several years, primarily as a result of the facility challenges that exist in the unit, it was at 74.6% of capacity in 2012 and 75.9% of capacity in 2013. Recognizing that senior adult populations are projected to grow at a more rapid rate than the rest of the population – 3.4% per year over the next five years – it is reasonable to assume that there is a continued need for the skilled nursing services being provided by PRMC's unit. Consideration was given to leaving the skilled nursing unit in the existing hospital and not relocating those beds to the replacement facility. The decision was made to pursue relocating the beds to the replacement hospital for three primary reasons. First, PRMC's thriving orthopedic program needs post-acute care that is efficient, cost-effective, and has high patient satisfaction. As both governmental and commercial payors continue to develop alternatives to fee-for-service, bundled payment models will become more and more prevalent. Joint replacements are uniquely suited to bundled payment arrangements, and it is important to be able to provide the highest quality, lowest cost care across the entire episode, from pre-operative consultations through post-acute stays. Having skilled nursing services within the hospital where joint replacement surgeries are performed is critical. Second, the current facility is difficult to navigate and is not the type of care environment that is best suited for patient recovery or satisfaction. Third, having skilled nursing beds within the hospital facility enables the unit to accept patients with greater medical needs than many nursing homes can provide.
2.	**Describe the relationship of this project to the applicant facility's long-range development plans, if any.**	The Hospital (including the skilled nursing beds) operates under the Tennova Healthcare brand identity and was previously known as Mercy Health System, which was formed in the 2008 merger of the St. Mary's and Baptist Health Systems. At that time, Mercy's leadership acknowledged that the combined system's hospital facilities needed to be right-sized as part of a long-range plan. That process began with the closure of Baptist Hospital of East Tennessee and has continued under new ownership with the development of additional services and capabilities at the Hospital's two other metro-Knoxville campuses, North Knoxville Medical Center and Turkey Creek Medical Center. In 2013, the Hospital relinquished 293 beds, removing excess capacity from the market. PRMC's related Certificate of Need application for the replacement hospital does not seek to regain any of the beds that were relinquished, but rather seeks to continue the long-range process of systematically right-sizing and maximizing the use, efficiency,

		and capability of the Hospital's healthcare facilities. In keeping with the changing nature of healthcare and the reimbursement challenges facing all hospital providers, building a replacement hospital for PRMC will allow the Hospital to optimize its resources while minimizing excess capacity in the overall system. In terms of the skilled nursing beds, relocating those beds to the replacement hospital facility will provide a much more patient-friendly environment that is also highly efficient. It will help to ensure that PRMC is able to provide high levels of care across the entire continuum, including post-acute care, particularly for sicker patients needing nursing home services and for post-operative orthopedic surgery patients.
3.		**Identify the proposed service area and justify the reasonableness of that proposed area. Submit a county level map including the State of Tennessee clearly marked to reflect the service area. Please submit the map on 8 1/2" x 11" sheet of white paper marked only with ink detectable by a standard photocopier (i.e., no highlighters, pencils, etc.).** The proposed service area for the project is a fifteen (15) county region of East Tennessee with Knoxville and Knox County at its center. The service area represents counties from which Physicians Regional Medical Center has historically drawn 95% of its skilled nursing patients. A map of the service area is attached as attachment C.Need.3. Because PRMC is a tertiary medical center with a regional reach, the current service area of the hospital is not expected to change with the relocation of the facility.
4.	A.	**Describe the demographics of the population to be served by this proposal.** In aggregate the service area is home to 1,197,466 residents, of which 982,449 are adults 15 and older. The table below summarizes 2014 service area population by county and age cohort based on projections published by Tennessee Department of Health.

PRMC SERVICE AREA POPULATION BY AGE COHORT 2014 ESTIMATES							
COUNTY	AGES 0-14	AGES 15-44	AGES 45-64	AGES 65-74	AGES 75-84	AGES 85+	TOTAL
Anderson	12,597	26,646	22,805	8,120	4,251	2,160	76,579
Blount	22,122	46,678	36,448	13,786	6,712	2,622	128,368
Campbell	7,248	15,085	11,527	4,626	2,297	691	41,474
Claiborne	5,428	12,235	9,061	3,607	1,747	526	32,604
Cocke	7,183	13,178	9,732	4,086	1,989	594	36,762
Grainger	4,152	8,259	6,496	2,662	1,210	332	23,111
Hamblen	12,184	24,019	16,636	6,593	3,461	1,215	64,108
Jefferson	12,658	16,475	14,624	6,201	2,956	815	53,729
Knox	79,869	184,855	122,513	39,019	19,270	8,103	453,629
Loudon	7,706	15,910	14,599	7,722	3,804	1,185	50,926
Monroe	10,877	13,257	13,020	5,712	2,454	772	46,092
Roane	8,525	17,679	16,380	6,759	3,356	1,307	54,006
Scott	4,372	8,252	5,779	2,151	1,038	352	21,944
Sevier	16,539	35,009	26,517	10,446	4,808	1,514	94,833
Union	3,557	6,946	5,627	2,033	882	256	19,301
Total	215,017	444,483	331,764	123,523	60,235	22,444	1,197,466
TENNESSEE	1,247,629	2,601,052	1,758,033	587,456	285,951	108,577	6,588,698

Source: Tennessee Population Projections 2010-2020, Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, 2013 Revision, and NHA Analysis

The service area population by county is presented in the table below, excluding those younger than 15.

Between 2014 and 2019, the service area is expected to grow by 62,257 residents, an overall growth rate of 5.2%. Its growth will outpace that of the State, which will experience a 4.6% increase. Several counties in the service area are expected to experience greater than average growth rates, such as Knox County with more than 27,000 new residents and a 6% growth factor, Blount County with nearly 9,000 new residents for a 6.8% increase, and Sevier County which is expected to grow by more than 7,000 people representing a 7.5% increase. All 15 counties will experience a growth in population.

PRMC SERVICE AREA POPULATION AGES 15+ CALENDAR YEARS 2014 THROUGH 2019						
COUNTY	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019
Anderson	63,982	64,514	64,988	65,403	65,809	66,217
Blount	106,246	107,786	109,494	111,070	112,663	114,387
Campbell	34,226	34,576	34,867	35,146	35,364	35,571
Claiborne	27,176	27,303	27,403	27,516	27,598	27,720
Cocke	29,579	29,660	27,449	29,830	29,929	30,047
Grainger	18,959	19,022	19,084	19,164	19,223	19,309
Hamblen	51,924	52,348	52,808	53,283	53,667	54,077
Jefferson	41,071	45,313	46,065	46,767	47,434	48,151
Knox	373,760	378,873	383,995	388,902	393,823	398,780
Loudon	43,220	43,894	44,535	45,174	45,759	46,324
Monroe	35,215	38,505	39,071	39,649	40,298	40,939
Roane	45,481	45,712	45,935	46,160	46,338	46,521
Scott	17,572	17,591	17,637	17,699	17,779	17,877
Sevier	78,294	79,506	80,722	81,879	83,165	84,450
Union	15,744	15,844	15,986	16,148	16,280	16,429
Service Area	982,449	1,000,447	1,010,039	1,023,790	1,035,129	1,046,799
TENNESSEE	5,341,069	5,400,137	5,457,971	5,514,469	5,569,916	5,625,869

Source: Tennessee Population Projections 2010-2020, Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, 2013 Revision, and NHA Analysis

Service Area population growth for those ages 15 and older, by county, between 2014 and 2019 is presented below.

PRMC SERVICE AREA POPULATION CHANGE AGES 15+ 2014 ESTIMATE AND 2019 FORECAST				
	Population Counts		2014-2019 Change	
COUNTY	2014 Estimate	2019 Forecasted	Change	Percent Change
Anderson	63,982	66,217	2,235	3.5%
Blount	106,246	114,387	8,141	7.7%
Campbell	34,226	35,571	1,345	3.9%
Claiborne	27,176	27,720	544	2.0%
Cocke	29,579	30,047	468	1.6%
Grainger	18,959	19,309	350	1.8%
Hamblen	51,924	54,077	2,153	4.1%
Jefferson	41,071	48,151	7,080	17.2%

Knox	373,760	398,780	25,020	6.7%
Loudon	43,220	46,324	3,104	7.2%
Monroe	35,215	40,939	5,724	16.3%
Roane	45,481	46,521	1,040	2.3%
Scott	17,572	17,877	305	1.7%
Sevier	78,294	84,450	6,156	7.9%
Union	15,744	16,429	685	4.4%
Service Area	982,449	1,046,799	64,350	6.5%
TENNESSEE	5,341,069	5,625,869	284,800	5.3%

Source: Tennessee Population Projections 2010-2020, Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, 2013 Revision, and NHA Analysis

While the overall service area population (ages 15 and older) is expected to grow 6.5% in the ensuing five years, the 65 and older cohort is expected to experience more significant growth, 16.7% between 2014 and 2019. Senior population along with other service area population and demographic characteristics are discussed in response to question 4B below.

B. Describe the special needs of the service area population, including health disparities, the accessibility to consumers, particularly the elderly, women, racial and ethnic minorities, and low-income groups. Document how the business plans of the facility will take into consideration the special needs of the service area population.

The Applicant intends to serve all residents of the service area and beyond, including those with unique demographic characteristics, health disparities, the elderly, women, racial and ethnic minorities, low-income groups and others. These groups are discussed below.

Senior Population

The service area is home to more than 206,000 residents age 65 and older. This cohort is expected to grow by 16.7% between 2014 and 2019. Knox County will experience the greatest growth rate (23.1%), an increase of more than 15,000 seniors, and Sevier County is anticipated to grow by more than 3,000 seniors. Knox and Sevier Counties have the first and second greatest concentration of senior population in the 15 county service area. Sevier County is contiguous to the southeast of Knox County. All 15 counties will experience a growth in this older adult population.

The service area's 16.7% growth rate in the senior population is expected to exceed the State's senior adult growth rate of 15.5%. The following table summarizes the current and expected population 65 years of age and older, by county, for 2014 and forecasted 2019, as well as the expected growth, numerical and percent change.

PRMC SERVICE AREA POPULATION CHANGE, AGES 65+ 2014 ESTIMATE AND 2019 FORECAST				
	Population Count		2014-2019 Change	
COUNTY	2014 Estimate	2019 Forecasted	Change	Percent Change
Anderson	14,531	16,737	2,206	15.2%
Blount	23,120	26,507	3,387	14.6%
Campbell	7,614	8,241	627	8.2%
Claiborne	5,880	6,471	591	10.1%
Cocke	6,669	6,905	236	3.5%
Grainger	4,204	4,607	403	9.6%
Hamblen	11,269	12,198	929	8.2%
Jefferson	9,972	11,606	1,634	16.4%
Knox	66,392	81,757	15,365	23.1%
Loudon	12,711	14,488	1,777	14.0%
Monroe	8,938	10,680	1,742	19.5%
Roane	11,422	12,863	1,441	12.6%
Scott	3,541	3,927	386	10.9%
Sevier	16,768	19,842	3,074	18.3%
Union	3,171	3,789	618	19.5%
Service Area	206,202	240,618	34,416	16.7%
TENNESSEE	981,984	1,134,565	152,581	15.5%

Source: Tennessee Population Projections 2010-2020, Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, 2013 Revision, and NHA Analysis

As indicated by the previous table, residents in the service area are aging and in fact, the growth amongst seniors is expected to account for half the total adult growth. This is significant when planning healthcare services for the future. It is clear that the rapid growth in the senior adult population will drive continued need for skilled nursing services, as well as a broad array of healthcare services.

Age of Population

The median age in the Service Area is 40.8 years and the average age is 40.5.

PRMC Service Area Median and Average Age Calendar Year 2014		
County	Median Age	Average Age
Anderson	43.4	42.1
Blount	42.5	41.4

Campbell	42.8	41.7
Claiborne	42.2	41.4
Cocke	44.2	42.2
Grainger	43.2	41.5
Hamblen	40.2	40.1
Jefferson	41.7	40.9
Knox	37.8	38.8
Loudon	47.0	44.3
Monroe	42.4	41.2
Roane	46.0	43.5
Scott	38.8	38.9
Sevier	41.9	40.9
Union	40.7	39.8
Service Area	40.8	40.5

Source: Claritas, Inc. and NHA Analysis

Household Characteristics

The service area is home to 475,511 households, an increase from nearly 467,000 as of the 2010 Census. The number of households in the 15 county service area is expected to increase to 489,429 by 2019. The average household income in the service area is $56,910 and the median income is $35,346. Household statistics by county for the service area follow.

	Number of Households			Household Income	
County	2010 Census	2014 Estimate	2019 Projection	Median	Average
Anderson	31,253	31,461	32,044	$43,918	$57,715
Blount	49,265	49,883	51,012	$44,083	$55,729
Campbell	16,354	16,106	16,034	$30,319	$39,769
Claiborne	12,853	12,563	12,363	$34,902	$45,640
Cocke	14,788	14,790	14,974	$27,994	$38,200
Grainger	9,029	9,022	9,098	$30,444	$41,331
Hamblen	24,560	24,526	24,722	$37,944	$50,478
Jefferson	19,864	20,349	21,070	$38,436	$51,011
Knox	177,249	183,063	190,856	$46,746	$64,913
Loudon	19,826	20,711	21,818	$51,749	$65,608
Monroe	17,711	18,141	18,745	$35,346	$48,079
Roane	22,376	21,918	21,685	$46,512	$62,328
Scott	8,671	8,658	8,739	$29,535	$38,483
Sevier	35,343	36,916	38,806	$42,674	$51,852
Union	7,391	7,404	7,463	$32,358	$41,909
Service Area	466,533	475,511	489,429	$42,264	$56,910
TENNESSEE	2,493,552	2,568,174	2,668,110	$43,390	$59,239

Source: Claritas, Inc. and NHA Analysis

The service area's median and average household incomes are 2.7% and 4.1% lower than the State of Tennessee overall, respectively.

TennCare Enrollees & Percent Below Poverty

There are nearly 205,000 TennCare enrollees in the service area, of which more than 62,000 reside in Knox County. TennCare enrollees as a percent of total county population range between 13.7% in Knox County to 31.7% in Scott County. 18.1% of the entire State's population is enrolled in TennCare. Nine of the 15 service area counties have greater percentages of their population enrolled in TennCare than the State average.

More than 16% of the service area's population is below the Federal poverty line, compared to 17.3% statewide. As with TennCare enrollment, 9 of the 15 service area counties have greater percentages of population below the poverty line than the State average. This information is presented on the table on the following page.

County	TennCare Enrollees	TennCare Enrollees as % of Total	Persons Below Poverty Level	Persons Below Poverty Level as % of Total
Anderson	13,771	18.00%	12,789	16.70%
Blount	18,646	14.50%	16,303	12.70%
Campbell	11,435	27.60%	9,829	23.70%
Claiborne	7,809	24.00%	7,499	23.00%
Cocke	9,766	26.60%	9,558	26.00%
Grainger	4,915	21.30%	4,668	20.20%
Hamblen	12,995	20.30%	11,924	18.60%
Jefferson	10,161	18.90%	10,316	19.20%
Knox	62,331	13.70%	64,415	14.20%
Loudon	7,026	13.80%	7,435	14.60%
Monroe	9,871	21.40%	8,896	19.30%
Roane	9,590	17.80%	7,777	14.40%
Scott	6,963	31.70%	5,662	25.80%
Sevier	15,120	15.90%	12,708	13.40%
Union	4,364	22.60%	4,362	22.60%
Service Area	204,763	17.10%	194,141	16.20%
Tennessee	1,190,766	18.10%	1,139,845	17.30%

Source: Tennessee Population Projections 2010-2020, Tennessee Department of Health, Division of Policy, Planning and Assessment, Office of Health Statistics, 2013 Revision, Claritas, Inc., U.S. Census Bureau and NHA Analysis

In addition to TennCare and poverty statistics, there are Medically Underserved Areas and Populations within PRMC's service area, as well as Health Professional Shortage Areas, as defined by the U.S. Department of Health and Human Services.

County	Medically Underserved Area / Population	Health Professional Shortage Area (Primary Care)
Anderson	Partial	No
Blount	Partial	No
Campbell	All	Yes
Claiborne	All	Yes
Cocke	All	Yes
Grainger	All	Yes
Hamblen	Partial	No
Jefferson	Partial	No
Knox	Partial	No
Loudon	All	No
Monroe	All	Yes
Roane	All	Yes
Scott	All	Yes
Sevier	Partial	Yes
Union	All	Yes

To summarize, key findings based on this data include the following:

- The senior population (65 years of age and older) is expected to experience population growth of 16.7% over the next five years;
- The service area's median age is 40.8 years;
- The median household income in the 15 county service area is $42,264;
- There are nearly 205,000 TennCare enrollees in the Service Area with Knox County accounting for 30.4% of these enrollees.
- TennCare enrollees as a percent of total county population range between 13.7% in Knox County to 31.7% in Scott County;
- More than 17% of the entire service area's population is enrolled in TennCare;
- 16.2% of the service area's total population is below the poverty line. Blount County has the lowest ratio of population below poverty, only 12.7%. In contrast, Scott and Cocke Counties have 25.8% and 26% of their population counts, respectively, below the poverty line.

5.	**Describe the existing or certified services, including approved but unimplemented CONs, of similar institutions in the service area. Include utilization and/or occupancy trends for each of the most recent three years of data available for this type of project. Be certain to list each institution and its utilization and/or occupancy individually. Inpatient bed projects must include the following data: admissions or discharges, patient days, and occupancy. Other projects should use the most appropriate measures, e.g., cases, procedures, visits, admissions, etc.**

Hospital-Based Skilled Nursing Units

There are six hospital-based skilled nursing units within the defined service area. Claiborne County Nursing Home in Claiborne County is the largest, licensed for 100 beds. In 2012 it achieved nearly 90 percent occupancy. LaFollette Health and Rehabilitation Center is the second largest hospital-based skilled nursing facility at 90 beds. It achieved an occupancy rate of 83.15% in 2012. Both Knox County hospital based skilled nursing units, at PRMC and at Ft. Sanders Regional Medical Center, are about the same size with 25 and 24 beds respectively. PRMC's unit was at 74% percent occupancy and Ft. Sanders 78% occupied in 2012. Fort Sanders' unit is the newest, having opened in 2011. Lastly, Ft. Sanders Sevier Nursing Home in Sevier County, within LeConte Medical Center, is a 54-bed unit with an average daily census of 45 patients. In aggregate these six skilled nursing units were at 85.65% occupancy in 2012; a chart reflecting that utilization follows.

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS
SUMMARY OF UTILIZATION
CALENDAR YEAR 2012

SKILLED NURSING UNIT	Beds	Admissions	Patient Days	ADC	Occupancy Rate
Physicians Regional Medical Center TCU	25	771	6,767	18.5	74.16%
Blount Memorial Transitional Care	76	1,252	25,213	69.1	90.90%
Claiborne County Nursing Home	100	220	32,745	89.7	89.70%
Fort Sanders Transitional Care	24	593	6,834	18.7	78.00%
Fort Sanders Sevier Nursing Home	54	120	16,556	45.4	84.00%
LaFollette Health & Rehabilitation Ctr	98	342	29,742	81.5	83.15%
Total	377	3,298	117,857	322.90	85.65%

Between 2010 and 2012 these skilled nursing admissions and patient days in the service area, on an aggregated basis, increased 36.7% and patient days increased by 39.6%. These changes do not include the two Ft. Sanders units, since neither unit was operational in 2010. All skilled nursing units increased in both admissions and patient days between 2010 and 2012 with the exception of PRMC, which declined in both admissions and patient days, primarily as a result of patient response to the aging facility.

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS ADMISSION AND PATIENT DAY TREND CALENDAR YEAR 2010 THROUGH 2012						
	Admissions/Discharges			*Patient Days*		
SKILLED NURSING UNIT	2010	2011	2012	2010	2011	2012
Physicians Regional Med Center TCU	822	810	771	7,413	6,810	6,767
Blount Memorial Transitional Care	1,138	1,186	1,252	25,760	26,292	25,213
Claiborne County Nursing Home	191	208	220	29,801	31,886	32,745
Fort Sanders Transitional Care	-	596	593	-	6,662	6,834
Fort Sanders Sevier Nursing Home	-	133	120	-	15,598	16,556
LaFollette Health & Rehabiltation Ctr	342	321	342	29,742	29,419	29,742
Total	2,151	2,916	2,941	62,974	87,187	87,923

		Change - Admissons	Percent Change		Change - Patient Days	Percent Change
Physicians Regional Med Center TCU		(51)	-6.2%		(646)	-8.7%
Blount Memorial Transitional Care		114	10.0%		(547)	-2.1%
Claiborne County Nursing Home		29	15.2%		2,944	9.9%
Fort Sanders Transitional Care		593	596.0%		6,834	-
Fort Sanders Sevier Nursing Home		120	133.0%		16,556	-
LaFollette Health & Rehabilitation Ctr		-	0.0%		-	0.0%
Total	--	790	36.7%	--	24,949	39.6%

Overall occupancy rates of hospital based skilled nursing units in the Service Area have remained virtually flat, even with the introduction of 78 new beds in 2011. Occupancy in 2010 was 85.8% in 201 licensed skilled nursing unit beds and increased slightly to 86.3% in 2012 with 279 beds in the service area. Occupancy rates at PRMC and Blount Memorial declined, but occupancy at Claiborne County Nursing Home grew from 81.6% in 2010 to 91% in 2012. Additionally, in its first year licensed as a hospital based skilled nursing unit, Ft. Sanders achieved 76% occupancy, and increased to 78% in 2012 and Ft. Sanders Sevier, in its first year, achieved 79% occupancy, increasing to 84% the next year.

The three year trend in occupancy rates for each provider is presented in the following table.

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS OCCUPANCY RATE TREND CALENDAR YEAR 2010 THROUGH 2012			
SKILLED NURSING UNIT	2010	2011	2012
Physicians Regional Medical Center TCU	81.20%	74.00%	72.10%
Blount Memorial Transitional Care	92.90%	94.80%	90.90%
Claiborne County Nursing Home	81.60%	87.40%	89.70%
Fort Sanders Transitional Care	--	76.10%	78.00%
Fort Sanders Sevier Nursing Home	--	79.10%	84.00%
LaFollette Health & Rehabilitation Ctr	83.14%	82.20%	83.14%
Total	85.80%	85.60%	86.30%

Source: Joint Annual Reports, Tennessee Department of Health and NHA Analysis

6. **Provide applicable utilization and/or occupancy statistics for your institution for each of the past three (3) years and the projected annual utilization for each of the two (2) years following completion of the project. Additionally, provide the details regarding the methodology used to project utilization. The methodology must include detailed calculations or documentation from referral sources, and identification of all assumptions.**

A chart showing utilization of skilled nursing services for the past three years at PRMC, as well as projections for the years during the proposed construction and the first two years in the replacement hospital is shown below.

Skilled Nursing	2011	2012	2013	2014 Annualized	2015	2016	2017	2018 - Project Year 1	2019 - Project Year 2
Admissions	810	771	730	687	697	708	718	742	767
Patient Days	6,810	6,767	6,930	6,958	6,935	7,039	7,145	7,383	7,630
ADC	18.7	18.5	19.0	19.1	19.0	19.3	19.6	20.2	20.9

Similar to overall hospital volumes at PRMC over the last several years, skilled nursing volumes have also declined, albeit at a slower rate than the acute care services. Given the significant projected growth in senior population in the service area over the next five years, it would be reasonable to expect that volumes in the skilled nursing area would increase. The primary factor driving the skilled nursing unit's lack of growth is the facility itself. In spite of being a hospital-based skilled nursing unit which enables the Hospital to provide care to patients requiring more medical management, it is more difficult to retain patients who have gone through orthopedic surgery and need more standard therapy-based skilled nursing care to utilize the services. Simply improving the physical appearance of the skilled nursing unit, particularly providing private showers and bathrooms that are equipped for patients utilizing walkers or wheelchairs, will provide an environment more conducive to attracting a greater number of patients.

In terms of future utilization, this application projects that volumes will stabilize and eventually improve in future years. As shown in the projected utilization chart above, volumes are projected to increase by 1.5% per year during the proposed years of construction (2015-2017), then 4% per year in the first two years in the replacement hospital. These projections are simply reflective of the population growth in the senior population (age 65 and older). Senior population is projected to grow at 3.34% per year over the next five years. It is not expected, due to the facility issues already outlined, that volumes will grow by the full 3.34% during the years when the replacement facility is being built, although some growth is anticipated (1.5% per year). Once construction is complete, it is projected that PRMC will capture its full, fair share of the population growth of 3.34% per year. There is no market share shift anticipated in this application.

PRMC Skilled Nursing Unit - Historic and Projected Utilization

Skilled Nursing	2011	2012	2013	2014 Annualized	2015	2016	2017	2018 - Project Year 1	2019 - Project Year 2
Admissions	810	771	730	687	697	708	718	742	767
Patient Days	6,810	6,767	6,930	6,958	6,935	7,039	7,145	7,383	7,630
ADC	18.7	18.5	19.0	19.1	19.0	19.3	19.6	20.2	20.9
Occupancy	74.6%	74.2%	75.9%	76.3%	76.0%	77.1%	78.3%	80.9%	83.6%

ECONOMIC FEASIBILITY

I.	**Provide the cost of the project by completing the Project Costs Chart on the following page. Justify the cost of the project.**	
	•	**All projects should have a project cost of at least $3,000 on Line F. (Minimum CON Filing Fee). CON filing fee should be calculated from Line D. (See Application Instructions for Filing Fee)** Confirmed – application fee is shown on Line F of the Project Costs Chart.
	•	**The cost of any lease (building, land, and/or equipment) should be based on fair market value or the total amount of the lease payments over the initial term of the lease, whichever is greater. Note: This applies to all equipment leases including by procedure or "per click" arrangements. The methodology used to determine the total lease cost for a "per click" arrangement must include, at a minimum, the projected procedures, the "per click" rate and the term of the lease.** Not applicable.
	•	**The cost for fixed and moveable equipment includes, but is not necessarily limited to, maintenance agreements covering the expected useful life of the equipment; federal, state, and local taxes and other government assessments; and installation charges, excluding capital expenditures for physical plant renovation or in-wall shielding, which should be included under construction costs or incorporated in a facility lease.** Confirmed. Equipment costs include installation, and sales taxes are reflected in the total equipment quote.
	•	**For projects that include new construction, modification, and/or renovation; documentation must be provided from a contractor and/or architect that support the estimated construction costs.** See attachment C.Economic Feasibility.I.a. Note that this application addresses a single unit in an entire replacement hospital facility. The contractor's quote for the entire facility has been attached, as well as a worksheet outlining the gross square footage planned for the skilled nursing unit and the construction cost calculation based on that square footage.

PROJECT COSTS CHART

A.	Construction and equipment acquired by purchase:		
	1.	Architectural and Engineering Fees	$ 347,805
	2.	Legal, Administrative (Excluding CON Filing Fee), Consultant Fees	$5,000
	3.	Acquisition of Site	
	4.	Preparation of Site	
	5.	Construction Costs	$5,895,000
	6.	Contingency Fund	
	7.	Fixed Equipment (Not included in Construction Contract)	$30,000
	8.	Moveable Equipment (List all equipment over $50,000)	$162,500
	9.	Other (Specify) _____	

B.	Acquisition by gift, donation, or lease:		
	1.	Facility (inclusive of building and land)	
	2.	Building only	
	3.	Land only	
	4.	Equipment (Specify) _____	
	5.	Other (Specify) _____	

C.	Financing Costs and Fees:		
	1.	Interim Financing	
	2.	Underwriting Costs	
	3.	Reserve for One Year's Debt Service	
	4.	Other (Specify) _____	

D.	Estimated Project Cost (A+B+C)	$6,440,305

E.	CON Filing Fee	$14,491

F.	Total Estimated Project Cost (D+E)	$6,454,796

	TOTAL	**$6,454,796**

operating revenue, and average net charge.

Inpatients:
Average gross charge - $14,368
Average deduction - $ 6,471
Average net charge - $ 7,897

2.	**Identify the funding sources for this project.** **Please check the applicable item(s) below and briefly summarize how the project will be financed. *(Documentation for the type of funding MUST be inserted at the end of the application, in the correct alpha/numeric order and identified as Attachment C, Economic Feasibility-2.)***	
__	**A.**	**Commercial loan--Letter from lending institution or guarantor stating favorable initial contact, proposed loan amount, expected interest rates, anticipated term of the loan, and any restrictions or conditions;charges.**
__	**B.**	**Tax-exempt bonds--Copy of preliminary resolution or a letter from the issuing authority stating favorable initial contact and a conditional agreement from an underwriter or investment banker to proceed with the issuance;**
__	**C.**	**General obligation bonds—Copy of resolution from issuing authority or minutes from the appropriate meeting.**
__	**D.**	**Grants--Notification of intent form for grant application or notice of grant award; or**
X	**E.**	**Cash Reserves--Appropriate documentation from Chief Financial Officer.** See attachment C.Economic Feasibility.2.
__	**F.**	**Other—Identify and document funding from all other sources.**
3.	**Discuss and document the reasonableness of the proposed project costs. If applicable,compare the cost per square foot of construction to similar projects recently approved by the Health Services and Development Agency.** Costs per square foot of construction in similar projects (new construction) recently approved by the Health Services and Development Agency are shown below: 1st Quartile: $235.00/sf; Median: $274.63/sf; 3rd Quartile: $324.00/sf Costs for this project are projected to be $300.00 / sf, which is between the median and 3rd quartile of the per square foot costs of other recently approved projects.	
4.	**Complete Historical and Projected Data Charts on the following two pages--*Do not modify the Charts provided or submit Chart substitutions!* Historical Data Chart represents revenue and expense information for the last *three (3)* years for which complete data is available for the institution. Projected Data Chart requests information for the two (2) years following the completion of this proposal. Projected Data Chart should reflect revenue and expense projections for the *Proposal Only* (*i.e.*, if the application is for additional beds, include anticipated revenue from the proposed beds only, not from all beds in the facility).** The Historical Data Chart and Projected Data Chart are complete.	
5.	**Please identify the project's average gross charge, average deduction from**	

HISTORICAL DATA CHART

Give information for the last *three (3)* years for which complete data are available for the facility or agency. The fiscal year begins in January.

			2011	2012	2013
A.		Utilization Data (Admissions)	810	771	730
B.		Revenue from Services to Patients			
	1	Inpatient Services	$ 9,717,732	$ 11,077,875	$ 10,488,779
	2	Outpatient Services	$ -	$ -	$ -
	3	Emergency Services	$ -	$ -	$ -
	4	Other Operating Revenue (Specify) Rent, Gift Shops	$ -	$ -	$ -
		Gross Operating Revenue	$ 9,717,732	$ 11,077,875	$ 10,488,779
C.		Deductions from Gross Operating Revenue			
	1	Contractual Adjustments	$ 6,156,568	$ 4,790,916	$ 4,536,146
	2	Provision for Charity Care	$ 172,030	$ 159,198	$ 150,732
	3	Provisions for Bad Debt	$ 47,334	$ 38,946	$ 36,875
		Total Deductions	$ 6,375,932	$ 4,989,060	$ 4,723,753
		NET OPERATING REVENUE	$ 3,341,800	$ 6,088,815	$ 5,765,026
D.		Operating Expenses			
	1	Salaries and Wages (incl. Benefits)	$ 1,485,510	$ 1,154,743	$ 1,102,300
	2	Physician's Salaries and Wages	$ -	$ -	$ -
	3	Supplies	$ 66,420	$ 62,954	$ 61,320
	4	Taxes	$ -	$ -	$ -
	5	Depreciation	$ -	$ -	$ -
	6	Rent	$ 12,052	$ 12,214	$ 12,214
	7	Interest, other than Capital	$ -	$ -	$ -
	8	Management Fees	$ -	$ -	$ -
	9	Other Expenses	$ 35,093	$ 1,608,844	$ 1,525,777
		Total Operating Expenses	$ 1,599,075	$ 2,838,755	$ 2,701,611
E.		Other Revenue (Expenses)			
		NET OPERATING INCOME (LOSS)	$ 1,742,725	$ 3,250,060	$ 3,063,415
F.		Capital Expenditures	$ -	$ -	$ -
		NET OPERATING INCOME (LOSS) LESS			
		CAPITAL EXPENDITURES	$ 1,742,725	$ 3,250,060	$ 3,063,415

	OTHER EXPENSES - BREAK DOWN BY CATEGORY				
	1	Outside Services	$ 12,960	$ 12,336	$ 11,680
	2	Repairs and Maintenance	$ 1,560	$ 1,412	$ 1,480
	3	Dues and Subscriptions	$ 7,321	$ 7,106	$ 6,984
	4	Misc Expenses	$ 13,252	$ 12,066	$ 13,513
	5	Ancillaries	$ -	$ 1,575,924	$ 1,492,120
			$ 35,093	$ 1,608,844	$ 1,525,777

			Year 1	Year 2
A.		Utilization Data (Admissions)	742	767
B.		Revenue from Services to Patients		
	1	Inpatient Services	$ 10,661,056	$ 11,020,256
	2	Outpatient Services	$ -	$ -
	3	Emergency Services	$ -	$ -
	4	Other Operating Revenue (Specify)_____		
		Gross Operating Revenue	$ 10,661,056	$ 11,020,256
C.		Deductions from Gross Operating Revenue		
	1	Contractual Adjustments	$ 4,610,788	$ 4,766,138
	2	Provision for Charity Care	$ 153,594	$ 158,769
	3	Provisions for Bad Debt	$ 37,842	$ 39,117
		Total Deductions	$ 4,802,224	$ 4,964,024
		NET OPERATING REVENUE	$ 5,858,832	$ 6,056,232
D.		Operating Expenses		
	1	Salaries and Wages	$ 1,111,516	$ 1,148,966
	2	Physician's Salaries and Wages	$ -	$ -
	3	Supplies	$ 63,812	$ 67,496
	4	Taxes	$ -	$ -
	5	Depreciation	$ -	$ -
	6	Rent	$ 12,261	$ 12,568
	7	Interest, other than Capital	$ -	$ -
	8	Management Fees	$ -	$ -
	9	Other Expenses	$ 1,569,245	$ 1,621,945
		Total Operating Expenses	$ 2,756,834	$ 2,850,975
E.		Other Revenue (Expenses)	$ -	$ -
		NET OPERATING INCOME	$ 3,101,998	$ 3,205,257
F.		Capital Expenditures	$ -	$ -
		NET OPERATING INCOME (LOSS) LESS CAPITAL EXPENDITURES	$ 3,101,998	$ 3,205,257

		OTHER EXPENSES - BREAK DOWN BY CATEGORY		
			Year One	Year Two
	1	Purchased Services	11,133	11,412
	2	Repairs and Maintenance	500	500
	3	Dues and Subscriptions	6,832	7,003
	4	Ancillaries	1,550,780	1,603,030
	5			
	6			
		Total	1,569,245	1,621,945

		OTHER EXPENSES - BREAK DOWN BY CATEGORY		
			Year One	Year Two
	1	Purchased Services	11,133	11,412
	2	Repairs and Maintenance	500	500
	3	Dues and Subscriptions	6,832	7,003
	4	Ancillaries	1,550,780	1,603,030
	5			
	6			
		Total	1,569,245	1,621,945

6.	A.	**Please provide the current and proposed charge schedules for the proposal. Discuss any adjustment to current charges that will result from the implementation of the proposal. Additionally, describe the anticipated revenue from the proposed project and the impact on existing patient charges.** Since the proposed project does not involve the implementation of new services or additional beds, we do not anticipate an increase in charges other than normal inflationary increases. See attachment C.Economic Feasibility.6 for a list of the highest volume charges for skilled nursing services, along with the charges for each.
	B.	**Compare the proposed charges to those of similar facilities in the service area/adjoining service areas, or to proposed charges of projects recently approved by the Health Services and Development Agency. If applicable, compare the proposed charges of the project to the current Medicare allowable fee schedule by common procedure terminology (CPT) code(s).** The Medicare RUG fee schedule, which is attached as attachment C.Economic Feasibility.6, outlines the per-day reimbursement that is allowable by Medicare for skilled nursing patients, based on each patient's RUG level, or classification of severity and required services. For Medicare patients, there is no difference between what is charged and the RUG reimbursement rate.
7.		**Discuss how projected utilization rates will be sufficient to maintain cost-effectiveness.** As indicated in the Projected Data Chart, admission volumes will stabilize in the years between this application and the completion of the replacement facility, due to the increase in senior adult population. Once the replacement facility is completed, the skilled nursing unit will benefit from having attractive new facilities, which will enable it to attract and keep patients at rates proportionate to population growth. Those volumes will enable the unit to be appropriately staffed and financially viable.
8.		**Discuss how financial viability will be ensured within two years; and demonstrate the availability of sufficient cash flow until financial viability is achieved.** As indicated in the Projected Data Chart, projected cash flow will ensure financial viability within the first year of the project and over the long term. As mentioned previously, to maintain the status quo would result in serious negative impact to the skilled nursing unit over time, given the antiquated facilities and the negative competitive forces in the market that are already being demonstrated.

9.	**Discuss the project's participation in state and federal revenue programs including a description of the extent to which Medicare, TennCare/Medicaid, and medically indigent patients will be served by the project. In addition, report the estimated dollar amount of revenue and percentage of total project revenue anticipated from each of TennCare, Medicare, or other state and federal sources for the proposal's first year of operation.** PRMC participates in both the Medicare and TennCare/Medicaid programs, as well as adhering to the charity policy put in place by the Sisters of Mercy. PRMC's 2013 payor mix for the skilled nursing unit by governmental payors is shown below. Medicare/Managed Medicare: 51% TennCare/Medicaid: 3% Other Governmental: 1% Self Pay: 2% The estimated dollar amount and percentage of gross revenue anticipated from each governmental payor during the proposed replacement hospital's first year of operation is shown below: Medicare/Managed Medicare: $ 5,479,783 / 51% TennCare/Medicaid: $ 319,832 / 3% Other Governmental: $ 106,611 / 1% Self Pay: $ 223,882 / 2%	
10.	**Provide copies of the balance sheet and income statement from the most recent reporting period of the institution and the most recent audited financial statements with accompanying notes, if applicable. For new projects, provide financial information for the corporation, partnership, or principal parties involved with the project. Copies must be inserted at the end of the application, in the correct alpha-numeric order and labeled as Attachment C, Economic Feasibility-10.** See attachment C.Economic Feasibility.10. Audited financial statements for CHS/Community Health Systems, Inc. in 2013 have been submitted, as verification of the financial health and funding capability of the Hospital's parent company.	
11.	**Describe all alternatives to this project which were considered and discuss the advantages and disadvantages of each alternative including but not limited to:**	
	a.	**A discussion regarding the availability of less costly, more effective, and/or more efficient alternative methods of providing the benefits intended by the proposal. If development of such alternatives is not practicable, the applicant should justify why not; including reasons as to why they were rejected.**

PRMC's proposed replacement and relocation project is designed to address critical issues that are compromising the hospital's long-term ability to serve patients and retain medical staff. A number of alternatives have been considered, but the replacement alternative that has been selected was done so as a means of stopping rapid declines in utilization by both physicians and patients, improve operating efficiencies and access, and employing the capital strategy with the best chance of a successful return.

Three of the major alternatives considered were (1) status quo, (2) renovation/refurbishment of the existing campus, (3) expansion of one of the Hospital's other metro Knoxville hospital campuses. Each of these three alternatives is considered in detail below.

(1) Status quo. As described throughout this application, continuing with the status quo was considered and rejected. By maintaining the status quo, PRMC will not just experience steady declines in volume, but will experience an additional significant and immediate shift in volume by key medical staff members. The costs to sustain a facility the size of the existing campus are substantial and reflect the environment of the past in which the hospital was built. Today's reimbursement and payment models no longer support a facility like PRMC, and in the interest of the orderly development of healthcare, the health system must right-size its resources.

(2) Renovation/remodel. Renovation or remodeling will not solve the hospital's critical issues:

1) Efficiency and accessibility issues. The existing campus has 1.5 million square feet and is spread over 13 buildings. The topography of the site, as well as the compressed acreage and lack of a cohesive master plan in the early decades of the hospital, drove development of buildings that are not easily navigable or reached from one another. The long distances and multiple elevators required are challenging for sick patients, confusing for family members, and inefficient for staff. While space to add another tower or patient care facility is very limited, it is possible to do on the existing site. However, additional space would only add to the efficiency and accessibility issues.

   Historic payment models were such that hospitals could afford to maintain higher levels of staffing in order to support a larger physical footprint and less efficient flow. With new payment models, downward pressure on reimbursement rates by governmental payers, and the challenges in gaining approvals for skilled nursing stays, hospitals like PRMC must focus resources on direct patient care and mission-critical support activities.

2. Infrastructure issues. The 13 buildings on the existing campus share electrical and HVAC infrastructure, making it very difficult and expensive to modify for renovation or additions. The entire campus is served by a single power plant with an interconnected electrical system. The hospital is served by three chillers, ranging in age from 17 to 37 years, and two boilers, one installed in 1955 and one in

		1977. The estimate to upgrade and replace the hospital infrastructure, which would be required in any major renovation or addition, is $80 million. This cost contributes nothing to the improvement of health services while adding to the cost of delivering healthcare. 3. Medical staff demand. The 450 members of PRMC's medical staff have overwhelmingly voiced concern that the existing hospital facility is no longer acceptable for many patients who are choosing to receive care in newer and more easily accessible environments. Because of the age and inaccessibility of the campus, as well as patient feedback, many physicians have chosen to move their offices away from PRMC. (3) Expansion of one of the Hospital's other metro Knoxville campuses. When considering the options to building a replacement hospital, an analysis was conducted to determine whether or not it is feasible to simply expand either Turkey Creek Medical Center, North Knoxville Medical Center, or both. Neither option was found to be viable for the following reasons: 1. Turkey Creek Medical Center has extremely limited expansion capabilities due to its landlocked position in the Turkey Creek development. There is little remaining space on the property to add on to the building, but even if a major addition were possible, there is no way to meet code in terms of available parking spaces without building a parking garage, which the strict City of Farragut zoning ordinances will not permit. 2. North Knoxville Medical Center provides plenty of space for expansion. However, because the facility infrastructure was only built to support the current capacity of 108 beds, not only would bed tower construction be required, but also additional infrastructure. The cost to expand North Knoxville Medical Center to meet the needs of the PRMC medical staff and patients is only slightly less than the cost to build a replacement hospital (estimated at $282 million). However, while North Knoxville Medical Center is very accessible to the northernmost portions of PRMC's current service area, it is not accessible to the southern and western portions of the service area, which are the areas of greatest growth. A 2010 study of the North Knoxville Medical Center service area by Navigant Consulting came back with the following quote: "Given the current population and healthcare needs in the Mercy North primary service area, Navigant does not believe that the region could fully support a tertiary campus for about another 10 years." In addition, the medical staff does not support moving the Hospital's tertiary main campus to North Knoxville Medical Center. For all the reasons listed above, it is important that the skilled nursing beds be relocated to the replacement hospital facility, if approved.
	b.	**The applicant should document that consideration has been given to alternatives to new construction, e.g., modernization or sharing**

		arrangements. It should be documented that superior alternatives have been implemented to the maximum extent practicable. Various upgrades of the existing facility have been completed to the point that it is practical and cost-effective. However, as has been demonstrated, more substantial renovations and restructuring is not cost-effective and would constitute a poor investment into infrastructure that will not meet the needs of the medical staff, patients, or PRMC over the coming decades, or the State's interest in the orderly development of healthcare services.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTH CARE

1.	**List all existing health care providers (e.g., hospitals, nursing homes, home care organizations, etc.), managed care organizations, alliances, and/or networks with which the applicant currently has or plans to have contractual and/or working relationships, e.g., transfer agreements, contractual agreements for health services.** The Hospital has contractual and working relationships with the following providers:

Asbury Acres HealthCare	Athens Community Hospital
Baptist Convalescent Center	Baptist Health Care Center
Brakebill Nursing Home	Blount Memorial Hospital
East Tennessee Children's Hospital	Briarcliff Health Care Center
Claiborne County Nursing Home	Claiborne County Hospital
Hillcrest Medical Nursing Institute	Farragut Healthcare
Holston Health and Rehabilitation Center	Hillhaven Health Care
Knoxville Convalescent Center	Jellico Community Hospital
Maynardville Community Medical Center	LifeCare Center
Northhaven Health Care Center	Morgan County Center for Health Care
Regency Health Care Center	Peninsula Hospital
Rockwood Health Care Center	Ridgeview Terrace of LifeCare
Serene Manor Medical Center	Shannondale Nursing Home
Parkwest Surgery Center	UT Medical Center – Knoxville
Vanderbilt University	Rural/Metro Ambulance Services
TN Division of Rehabilitation Services	Laughlin Memorial Hospital
Knoxville Surgery Center	Takoma Adventist Hospital
Lafollette Medical Center	NHC, Fort Sanders of Knoxville
Tennessee Nursing Services, Inc.	Physicians Surgery Center
Wellington Place of Kingston	Select Specialty Hospital - North Knoxville, Inc.

2. Describe the positive and/or negative effects of the proposal on the health care system. Please be sure to discuss any instances of duplication or competition arising from your proposal including a description of the effect the proposal will have on the utilization rates of existing providers in the service area of the project.

Providing access to state-of-the-art, efficient, and accessible health care services will have a beneficial effect on the healthcare system. Ensuring the long-term viability of a tertiary care hospital in the service area will be beneficial to the overall system of healthcare. Providing high quality post-acute services inside the hospital facility will enable continuity of care for those patients transitioning into skilled nursing following an acute care stay.

There will be no duplication of services or impact to other providers in the area, since this proposal simply takes services that are already in place, right-sizes them to the current demand (reducing the active beds in the market by 91), and replaces them in a more efficient facility that is easier for patients to navigate and less costly for the Hospital to operate.

3. Provide the current and/or anticipated staffing pattern for all employees providing patient care for the project. This can be reported using FTEs for these positions. Additionally, please compare the clinical staff salaries in the proposal to prevailing wage patterns in the service area as published by the Tennessee Department of Labor & Workforce Development and/or other documented sources.

Projected staffing for the skilled nursing unit is:
Registered Nurses – 8 FTEs
Licensed Practical Nurses – 5 FTEs
Certified Nursing Assistants – 7 FTEs
Unit Clerk – 1 FTE

Current wage rates for key positions within the hospital are shown in the following chart.

	PRMC, Current Wage Rates		
Occupational Title	**Min**	**Mid**	**Max**
Licensed Practical and Licensed Vocational Nurses	$ 13.10	$ 16.40	$ 19.65
Nursing Aides, Orderlies, and Attendants	$ 9.95	$ 12.45	$ 14.95
Registered Nurses	$ 18.00	$ 21.00	$ 31.45

The prevailing wages for 2013 for both the State of Tennessee as well as the Knoxville MSA, as reported by the Tennessee Department of Labor and Workforce Development are shown below.

	Tennessee, 2013				
Occupational Title	Mean	Entry Level	Experienced	Median	
Licensed Practical and Licensed Vocational Nurses	$ 17.40	$ 14.55	$ 18.80	$ 19.40	
Nursing Aides, Orderlies, and Attendants	$ 10.95	$ 8.85	$ 12.00	$ 10.70	
Registered Nurses	$ 26.85	$ 21.00	$ 29.75	$ 26.50	

Knoxville, TN MSA, 2013				
Occupational Title	Mean	Entry Level	Experienced	Median
Licensed Practical and Licensed Vocational Nurses	$ 16.95	$ 14.40	$ 18.25	$ 16.70
Nursing Aides, Orderlies, and Attendants	$ 10.05	$ 8.05	$ 11.05	$ 10.00
Registered Nurses	$ 25.55	$ 21.25	$ 27.70	$ 25.65

4. Discuss the availability of and accessibility to human resources required by the proposal, including adequate professional staff, as per the Department of Health, the Department of Mental Health and Developmental Disabilities, and/or the Division of Mental Retardation Services licensing requirements.

Because this is a relocation/replacement project and not a new service, it is anticipated that most if not all needed staff will transfer from the existing hospital site to the new location. However, when new staff is needed, the metro Knoxville area does have adequate professional staff to meet the needs of the hospital.

5. Verify that the applicant has reviewed and understands all licensing certification as required by the State of Tennessee for medical/clinical staff. These include, without limitation, regulations concerning physician supervision, credentialing, admission privileges, quality assurance policies and programs, utilization review *policies and programs, record keeping, and staff education.*

The applicant has reviewed and understands all licensing certification required by the State of Tennessee for medical/clinical staff.

6. Discuss your health care institution's participation in the training of students in the areas of medicine, nursing, social work, etc. (*e.g.*, internships, residencies, etc.).

The Hospital has education affiliations with the following schools and organizations:

AT Still University (Arizona School of Health Sciences)
Carson Newman College
Creighton University
East Tennessee State University
Grace Academy
Independence University
Iowa College Acquisition Co (Kaplan University)
Lincoln Memorial University
Pellissippi State Community College

	Roane State Community College South College Tennessee Technical College at Jacksboro Tennessee Technical College of Knoxville Tennessee Technical College of Oneida Union Co Schools University of New England University of Miami University of North Carolina at Chapel Hill University of Tennessee, Knoxville University of Tennessee, Memphis Vanderbilt University Walden University Walters State University Wesleyan College Fort Sanders Nursing Dept.	
7.	(a)	**Please verify, as applicable, that the applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, and/or any applicable Medicare requirements.** The applicant has reviewed and understands the licensure requirements of the Department of Health, the Department of Mental Health and Developmental Disabilities, the Division of Mental Retardation Services, as well as Medicare requirements.
	(b)	**Provide the name of the entity from which the applicant has received or will receive licensure, certification, and/or accreditation.** **Licensure:** Tennessee Department of Health, Board for Licensing Health Care Facilities
	(c)	**If an existing institution, please describe the current standing with any licensing, certifying, or accrediting agency. Provide a copy of the current license of the facility.** The skilled nursing unit is in good standing with all licensing and certifying agencies. A copy of the skilled nursing license is attached as attachment C.Orderly Development.7.c.
	(d)	**For existing licensed providers, document that all deficiencies (if any) cited in the last licensure certification and inspection have been addressed through an approved plan of correction. Please include a copy of the most recent licensure/certification inspection with an approved plan of correction.** The Hospital is in good standing with all licensing agencies. A copy of the most recent State inspection is attached as attachment C.Orderly

		Development.7.d.
8.	**Document and explain any final orders or judgments entered in any state or country by a licensing agency or court against professional licenses held by the applicant or any entities or persons with more than a 5% ownership interest in the applicant. Such information is to be provided for licenses regardless of whether such license is currently held.** While there are no final orders or judgments entered by a licensing agency, there is a civil judgment against one of the metro Knoxville hospital campuses, North Knoxville Medical Center. The judgment is against the former owner of the hospital, Mercy Health System, and is being appealed.	
9.	**Identify and explain any final civil or criminal judgments for fraud or theft against any person or entity with more than a 5% ownership interest in the project.** There are none.	
10.	**If the proposal is approved, please discuss whether the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as required.** If the proposal is approved, the applicant will provide the Tennessee Health Services and Development Agency and/or the reviewing agency information concerning the number of patients treated, the number and type of procedures performed, and other data as requested.	

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PROOF OF PUBLICATION

Attach the full page of the newspaper in which the notice of intent appeared with the mast and dateline intact or submit a publication affidavit from the newspaper as proof of the publication of the letter of intent.

DEVELOPMENT SCHEDULE

Tennessee Code Annotated § 68-11-1609(c) provides that a Certificate of Need is valid for a period not to exceed three (3) years (for hospital projects) or two (2) years (for all other projects) from the date of its issuance and after such time shall expire; provided, that the Agency may, in granting the Certificate of Need, allow longer periods of validity for Certificates of Need for good cause shown. Subsequent to granting the Certificate of Need, the Agency may extend a Certificate of Need for a period upon application and good cause shown, accompanied by a non-refundable reasonable filing fee, as prescribed by rule. A Certificate of Need which has been extended shall expire at the end of the extended time period. The decision whether to grant such an extension is within the sole discretion of the Agency, and is not subject to review, reconsideration, or appeal.

1. **Please complete the Project Completion Forecast Chart on the next page. If the project will be completed in multiple phases, please identify the anticipated completion date for each phase.**
2. **If the response to the preceding question *indicates that the applicant does not anticipate completing the project within the period of validity as defined in the preceding paragraph,* please state below any request for an extended schedule and document the "good cause" for such an extension.**

Form HF0004
Revised 02/01/06
Previous Forms are obsolete

AFFIDAVIT

STATE OF Tennessee

COUNTY OF Knox

Melanie B. Burgess, being first duly sworn, says that he/she is the applicant named in this application or his/her/its lawful agent, that this project will be completed in accordance with the application, that the applicant has read the directions to this application, the Rules of the Health Services and Development Agency, and T.C.A. § 68-11-1601, *et seq.*, and that the responses to this application or any other questions deemed appropriate by the Health Services and Development Agency are true and complete.

Melanie B Burg VP
SIGNATURE/TITLE

Sworn to and subscribed before me this 12 day of August (Month), 2014 (Year) a Notary Public in and for the County/State of Tennessee.

Linda R. Cooper
NOTARY PUBLIC

My commission expires Sept. 11 (Month/Day), 2017 (Year).

LINDA R. COOPER STATE OF TENNESSEE NOTARY PUBLIC KNOX COUNTY

PROJECT COMPLETION FORECAST CHART

November 19, 2014 T.C.A. § 68-11-1609(c): _____

Assuming the CON approval becomes the final agency action on that date; indicate the number of days **from the above agency decision date** to each phase of the completion forecast.

Phase	**DAYS REQUIRED**	**Anticipated Date (MONTH/YEAR)**
1. Architectural and engineering contract signed	30 days	January, 2015
2. Construction documents approved by the Tennessee Department of Health	440 days	February, 2016
3. Construction contract signed	470 days	March, 2016
4. Building permit secured	530 days	May, 2016
5. Site preparation completed	620 days	August, 2016
6. Building construction commenced	625 days	August, 2016
7. Construction 40% complete	805 days	February, 2017
8. Construction 80% complete	1,065 days	November, 2017
9. Construction 100% complete (approved for occupancy	1,195 days	March, 2018
10. *Issuance of license	1,205 days	March, 2018
11. *Initiation of service	1,215 days	April, 2018
12. Final Architectural Certification of Payment	1,240 days	May, 2018
13. Final Project Report Form (HF0055)	1,270 days	June, 2018

*** For projects that do NOT involve construction or renovation: Please complete items 10 and 11 only.**

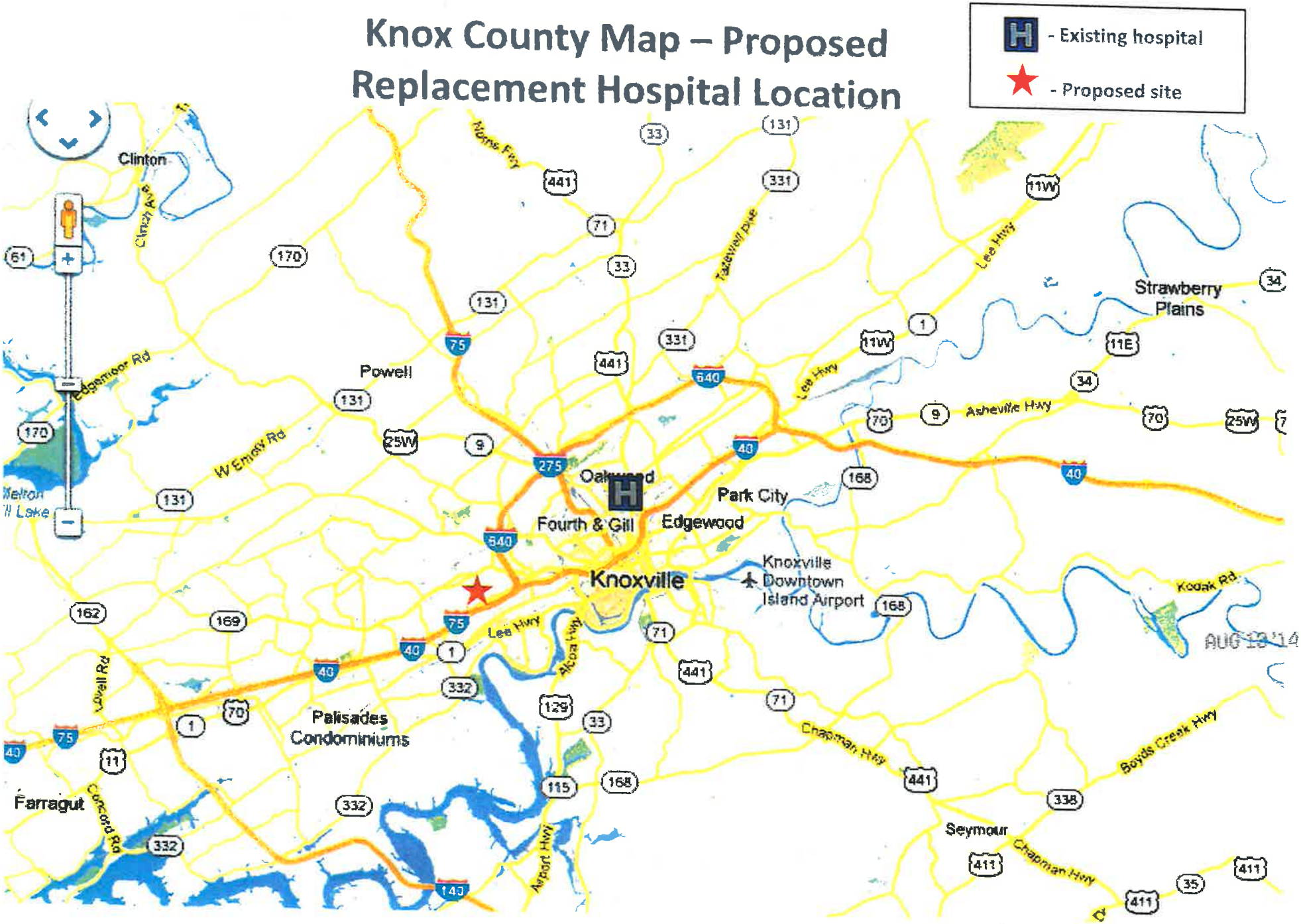
Note: If litigation occurs, the completion forecast will be adjusted at the time of the final determination to reflect the actual issue date.

List of Attachments

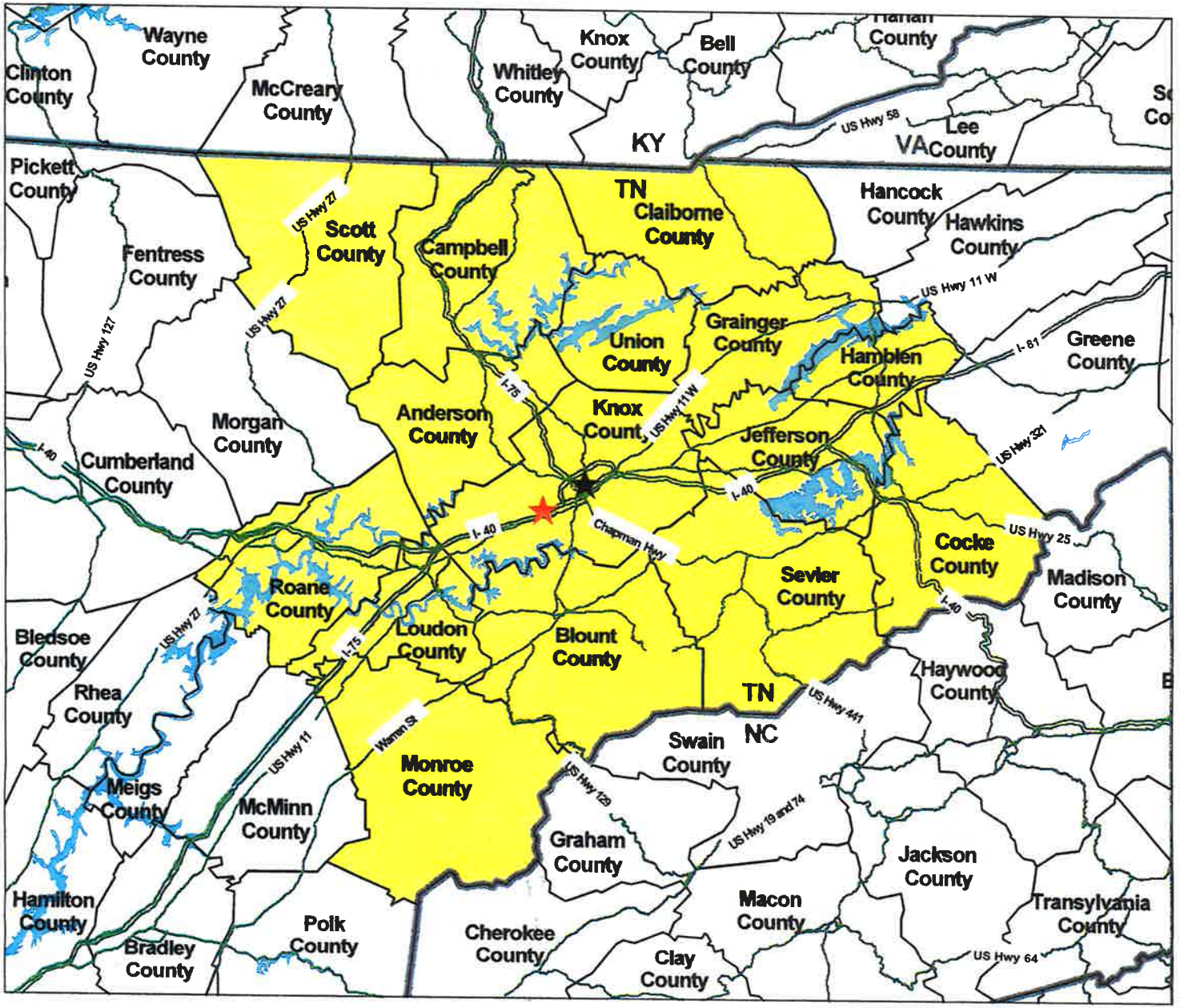
Attachment A.4.	Hospital Organizational documents
Attachment B.I.Project Description.1	Maps of proposed replacement hospital site
Attachment B.I.Project Description.2	Option contract for land
Attachment B.I.Project Description.3	Corporate Ownership Listing
Attachment B.I.Project Description.4	Service Area Map
Attachment B.II.E.3	Furniture and Equipment list
Attachment B.III.(A)	Plot Plan of Site
Attachment B.III.B.a	Map of Knoxville Area Transit bus routes
Attachment B.III.B.b	Map of Crosstown Connector bus route
Attachment B.IV	Floor Plan
Attachment C.Need.3	Service Area Map
Attachment C.Economic Feasibility.1	Contractor's Quote
Attachment C.Economic Feasibility.2	CFO Letter
Attachment C.Economic Feasibility.6	Charge schedule
Attachment C.Economic Feasibility.10	Audited Financial Statements
Attachment C.Orderly Development.7.c	License for Skilled Nursing Beds
Attachment C.Orderly Development.7.d	Most Recent Survey Inspection Report

Attachment B.I.Project Description.1

Knox County Map – Proposed Replacement Hospital Location



PRMC Replacement Hospital



LEGEND

- Service Area
- Replacement Hospital
- Existing PRMC

SOURCE: PMD Advisory Services, LLC and The Nielsen Company, 06/14/2014. www.PMDAS.com

N

Miles

0 10 20 30 40

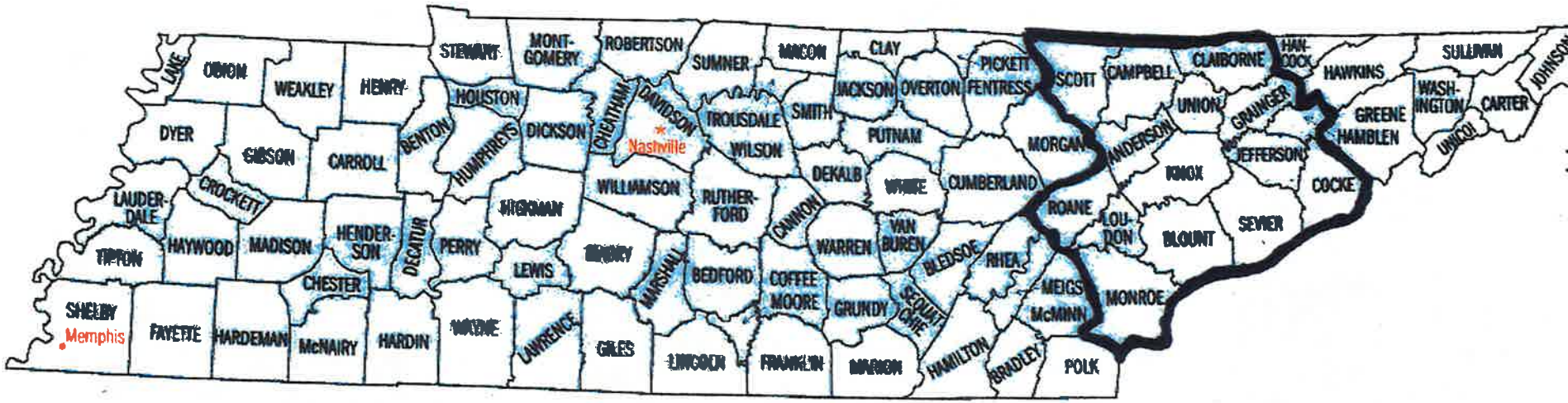
NH

74

AUG 13 '14 PM 1

Attachment B.I.Project Description.3

Attachment B.I.Project Description.4


LAKE
OBION
WEAKLEY
HENRY
STEWART
MONT-GOMERY
ROBERTSON
SUMNER
MACON
CLAY
PICKETT
FENTRESS
SCOTT
CAMPBELL
CLAIBORNE
HAN-COCK
HAWKINS
SULLIVAN
JOHNSON
WASH-INGTON
CARTER
UNICOI
GREENE
HAMBLEN
GRAINGER
UNION
JEFFERSON
COCKE
SEVIER
BLOUNT
KNOX
ANDERSON
LOU-DON
ROANE
MORGAN
CUMBERLAND
WHITE
DEKALB
PUTNAM
OVERTON
JACKSON
SMITH
TROUSDALE
WILSON
DAVIDSON
Nashville
CHEATHAM
DICKSON
HOUSTON
BENTON
HUMPHREYS
CARROLL
GIBSON
DYER
CROCKETT
LAUDER-DALE
TIPTON
HAYWOOD
MADISON
HENDER-SON
CHESTER
DECATUR
PERRY
HICKMAN
WILLIAMSON
RUTHER-FORD
CANNON
WARREN
VAN BUREN
BLEDSOE
RHEA
MEIGS
McMINN
MONROE
POLK
BRADLEY
HAMILTON
SEQUATCHIE
GRUNDY
COFFEE
MOORE
BEDFORD
MARSHALL
LEWIS
HENRY
SHELBY
Memphis
FAYETTE
HARDEMAN
McNAIRY
HARDIN
WAYNE
LAWRENCE
GILES
LINCOLN
FRANKLIN
MARION

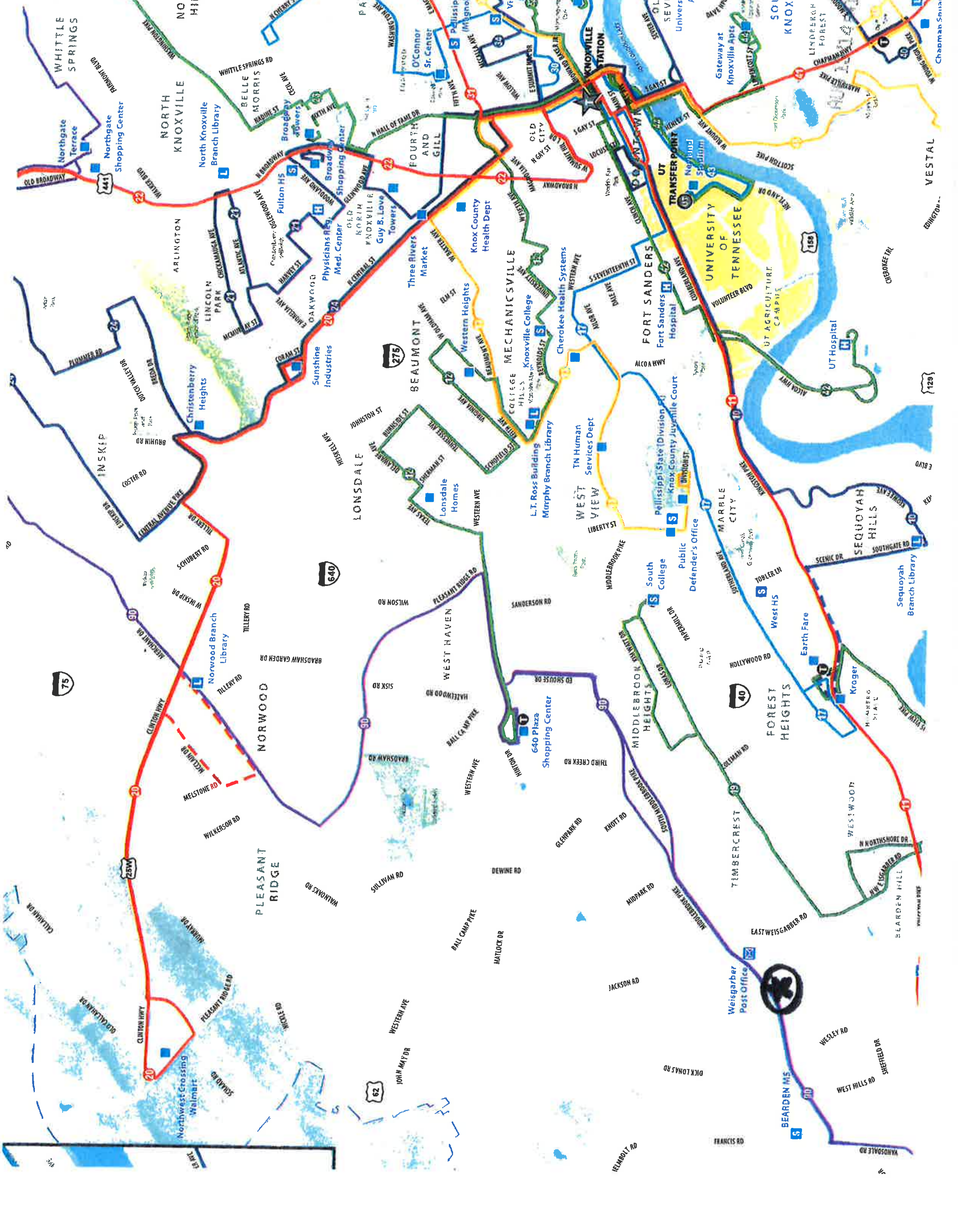
JULY 1, 2014

CONCEPT PLAN EXHIBIT
PHYSICIANS REGIONAL MEDICAL CENTER
KNOXVILLE, TN

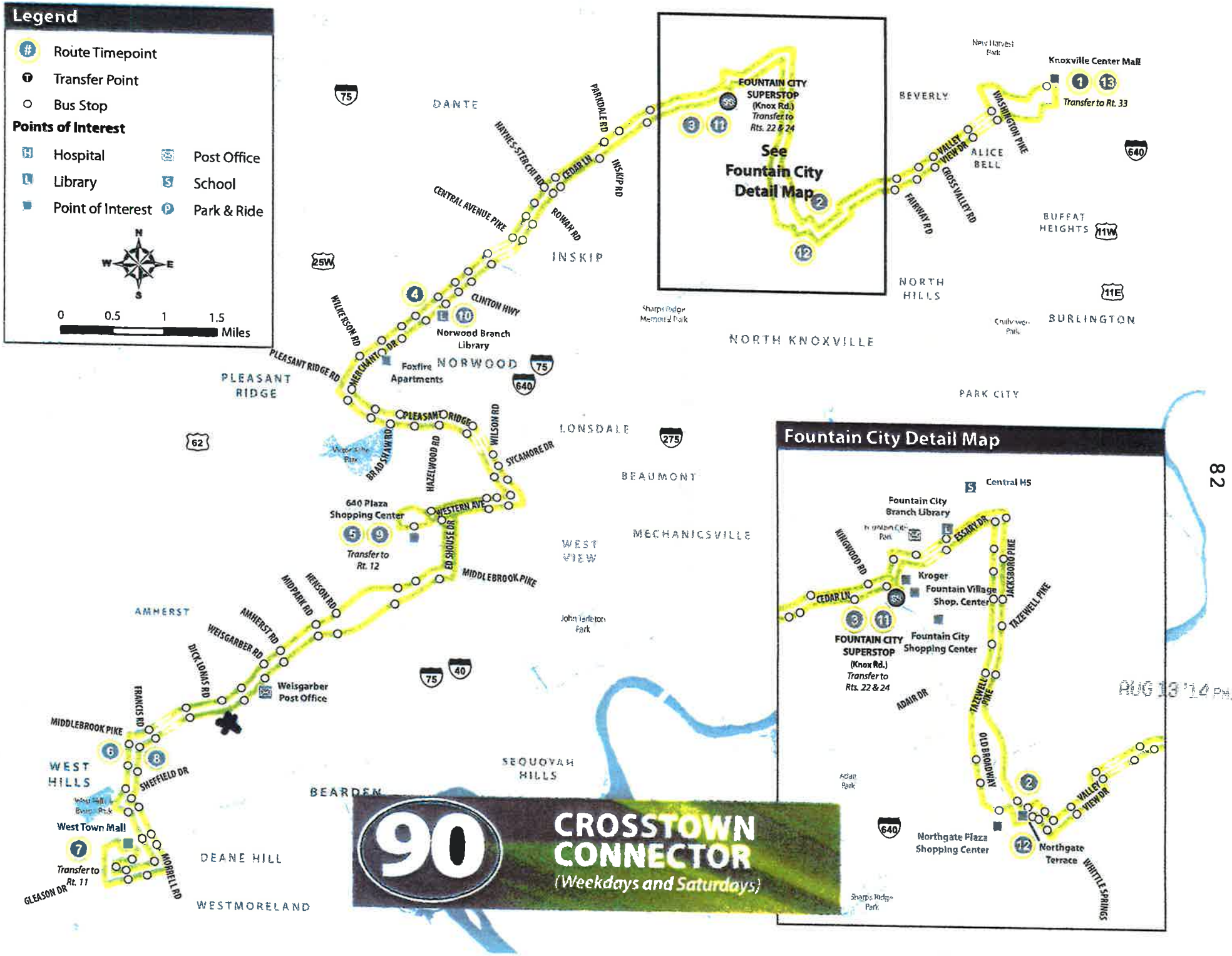
Littlejohn

tmp

Attachment B.III.B.a


KNOXVILLE STATION
DOWNTOWN
UT TRANSFER POINT
Neyland Stadium
UNIVERSITY OF TENNESSEE
UT AGRICULTURE CAMPUS
UT Hospital
FORT SANDERS
Fort Sanders Hospital
Cherokee Health Systems
MECHANICSVILLE
Knoxville College
COLLEGE HILLS
L.T. Ross Building
Murphy Branch Library
BEAUMONT
Western Heights
Knox County Health Dept
Three Rivers Market
FOURTH AND GILL
OLD NORTH KNOXVILLE
Guy B. Love Towers
Broadway Shopping Center
Broadway Towers
Physicians Reg. Med. Center
Fulton HS
NORTH KNOXVILLE
North Knoxville Branch Library
Northgate Terrace
Northgate Shopping Center
WHITTLE SPRINGS
BELLE MORRIS
O'Connor Sr. Center
OLD CITY
Pellissippi (Magnolia)
ARLINGTON
LINCOLN PARK
OAKWOOD
Sunshine Industries
Christenberry Heights
INSKIP
LONSDALE
Lonsdale Homes
WEST VIEW
TN Human Services Dept
Pellissippi State (Division St)
Knox County Juvenile Court
Public Defender's Office
South College
MARBLE CITY
West HS
Earth Fare
Kroger
SEQUOYAH HILLS
Sequoyah Branch Library
FOREST HEIGHTS
MIDDLEBROOK HEIGHTS
TIMBERCREST
WESTWOOD
BEARDEN HILL
Weisgarber Post Office
BEARDEN MS
WEST HAVEN
640 Plaza Shopping Center
NORWOOD
Norwood Branch Library
PLEASANT RIDGE
Northwest Crossing Walmart
Gateway at Knoxville Apts
LINDBERGH FOREST
Chapman Square
VESTAL
OLD SEVIER
KINGSTON PIKE
CLINTON HWY
MIDDLEBROOK PIKE
WESTERN AVE
CENTRAL AVENUE PIKE
MERCHANT DR
ALCOA HWY
SUTHERLAND AVE
VOLUNTEER BLVD
CUMBERLAND AVE
N BROADWAY
N CENTRAL ST
HALL OF FAME DR
ED SHOUSE DR
PLEASANT RIDGE RD
EAST WEISGARBER RD
MELSTONE RD

Attachment B.III.B.b


Legend
Route Timepoint
Transfer Point
Bus Stop
Points of Interest
Hospital
Library
Point of Interest
Post Office
School
Park & Ride
N
W
E
S
0
0.5
1
1.5
Miles
DANTE
INSKIP
NORTH KNOXVILLE
BEVERLY
ALICE BELL
BUFFAT HEIGHTS
NORTH HILLS
BURLINGTON
PLEASANT RIDGE
NORWOOD
LONSDALE
BEAUMONT
MECHANICSVILLE
PARK CITY
WEST VIEW
AMHERST
WEST HILLS
SEQUOYAH HILLS
BEARDEN
DEANE HILL
WESTMORELAND
FOUNTAIN CITY SUPERSTOP (Knox Rd.) Transfer to Rts. 22 & 24
See Fountain City Detail Map
Knoxville Center Mall
Transfer to Rt. 33
Norwood Branch Library
Foxfire Apartments
640 Plaza Shopping Center
Transfer to Rt. 12
Weisgarber Post Office
West Town Mall
Transfer to Rt. 11
Fountain City Detail Map
Central HS
Fountain City Branch Library
Kroger
Fountain Village Shop. Center
Fountain City Shopping Center
Northgate Plaza Shopping Center
Northgate Terrace
90
CROSSTOWN CONNECTOR
(Weekdays and Saturdays)

Going toward West Town Mall

Transfer to:		Rts. 22 & 24			Rt. 12			Rt. 11			Rt. 12			Rts. 22 & 24			Rt. 33
Knoxville Center Mall	Northgate Terrace	Fountain City Superstop (Arrives)	(Leaves)	Merchants at Expo Center	I-640 Plaza (Arrives)	(Leaves)	Vanosdale at Middlebrook	West Town Mall (Arrives)	(Leaves)	Vanosdale at Middlebrook	I-640 Plaza (Arrives)	(Leaves)	Merchants at Marguerite	Fountain City Superstop (Arrives)	(Leaves)	Northgate Terrace	Knoxville Center Mall
1	2	3		4	5		6	7		8	9		10	11		12	13
WEEKDAY SCHEDULE																	
A.M.									6:01	6:06	6:20	6:22	6:37	7:00	7:05	7:11	7:25
				6:05	6:17	6:37	6:39	6:46	6:59	7:01	7:06	7:20	7:22	7:37	8:00	8:05	8:11	8:25
	6:30	6:45	7:00	7:05	7:17	7:37	7:39	7:46	7:59	8:01	8:06	8:20	8:22	8:37	9:00	9:05	9:11	9:25
	7:30	7:45	8:00	8:05	8:17	8:37	8:39	8:46	8:59	9:01	9:06	9:20	9:22	9:37	10:00	10:05	10:11	10:25
	8:30	8:45	9:00	9:05	9:17	9:37	9:39	9:46	9:59	10:01	10:06	10:20	10:22	10:37	11:00	11:05	11:11	11:25
	9:30	9:45	10:00	10:05	10:17	10:37	10:39	10:46	10:59	11:01	11:06	11:20	11:22	11:37	12:00	12:05	12:11	12:25
	10:30	10:45	11:00	11:05	11:17	11:37	11:39	11:46	11:59	12:01	12:06	12:20	12:22	12:37	1:00	1:05	1:11	1:25
	11:30	11:45	12:00	12:05	12:17	12:37	12:39	12:46	12:59	1:01	1:06	1:20	1:22	1:37	2:00	2:05	2:11	2:25
P.M.	12:30	12:45	1:00	1:05	1:17	1:37	1:39	1:46	1:59	2:01	2:06	2:20	2:22	2:37	3:00	3:05	3:11	3:25
	1:30	1:45	2:00	2:05	2:17	2:37	2:39	2:46	2:59	3:01	3:06	3:20	3:22	3:37	4:00	4:05	4:11	4:25
	2:30	2:45	3:00	3:05	3:17	3:37	3:39	3:46	3:59	4:01	4:06	4:20	4:22	4:37	5:00	5:05	5:11	5:25
	3:30	3:45	4:00	4:05	4:17	4:37	4:39	4:46	4:59	5:01	5:06	5:20	5:22	5:37	6:00	6:05	6:11	6:25
	4:30	4:45	5:00	5:05	5:17	5:37	5:39	5:46	5:59	6:01	6:06	6:20	6:22	6:37	7:00	7:05	7:11	7:25
	5:30	5:45	6:00	6:05	6:17	6:37	6:39	6:46	6:59	7:01	7:06	7:20	7:22	7:37	8:00	8:05	8:11	8:25
	6:30	6:45	7:00	7:05	7:17	7:37	7:39	7:46	7:59	To Garage								
	7:30	7:45	8:00	8:05	8:17	8:37	8:39	8:46	8:59	To Garage								
SATURDAY SCHEDULE																	
A.M.										7:31	7:39	7:59	8:04	8:14	8:30	8:35	8:41	8:55
	7:00	7:15	7:30	7:35	7:47	8:08	8:12	8:20	8:29	8:31	8:39	8:59	9:04	9:14	9:30	9:35	9:41	9:55
	8:00	8:15	8:30	8:35	8:47	9:08	9:12	9:20	9:29	9:31	9:39	9:59	10:04	10:14	10:30	10:35	10:41	10:55
	9:00	9:15	9:30	9:35	9:47	10:08	10:12	10:20	10:29	10:31	10:39	10:59	11:04	11:14	11:30	11:35	11:41	11:55
	10:00	10:15	10:30	10:35	10:47	11:08	11:12	11:20	11:29	11:31	11:39	11:59	12:04	12:14	12:30	12:35	12:41	12:55
	11:00	11:15	11:30	11:35	11:47	12:08	12:12	12:20	12:29	12:31	12:39	12:59	1:04	1:14	1:30	1:35	1:41	1:55
P.M.	12:00	12:15	12:30	12:35	12:47	1:08	1:12	1:20	1:29	1:31	1:39	1:59	2:04	2:14	2:30	2:35	2:41	2:55
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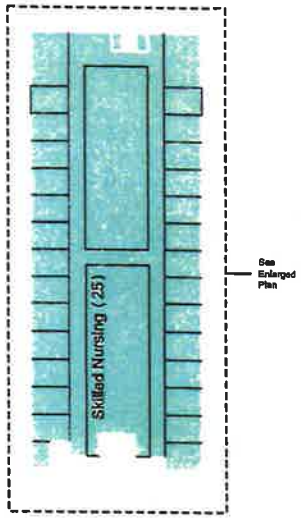
	2:00	2:15	2:30	2:35	2:47	3:08	3:12	3:20	3:29	3:31	3:39	3:59	4:04	4:14	4:30	4:35	4:41	4:55
	3:00	3:15	3:30	3:35	3:47	4:08	4:12	4:20	4:29	4:31	4:39	4:59	5:04	5:14	5:30	5:35	5:41	5:55
	4:00	4:15	4:30	4:35	4:47	5:08	5:12	5:20	5:29	5:31	5:39	5:59	6:04	6:14	6:30	6:35	6:41	6:55
	5:00	5:15	5:30	5:35	5:47	6:08	6:12	6:20	6:29	6:31	6:39	6:59	7:04	7:14	7:30	7:35	7:41	7:55
	6:00	6:15	6:30	6:35	6:47	7:08	7:12	7:20	7:29	7:31	7:39	7:59	8:04	8:14	8:30	8:35	8:41	8:55
	7:00	7:15	7:30	7:35	7:47	8:08	8:12	8:20	8:29	To Garage								

Going toward Knoxville Center Mall

Need help reading this schedule?
Need other general information on how to ride?
Click here to Download the General Schedule Information pdf available from katbus.com

Attachment B.IV



Existing Fourth Floor of Hospital

Existing Fourth Floor of Hospital

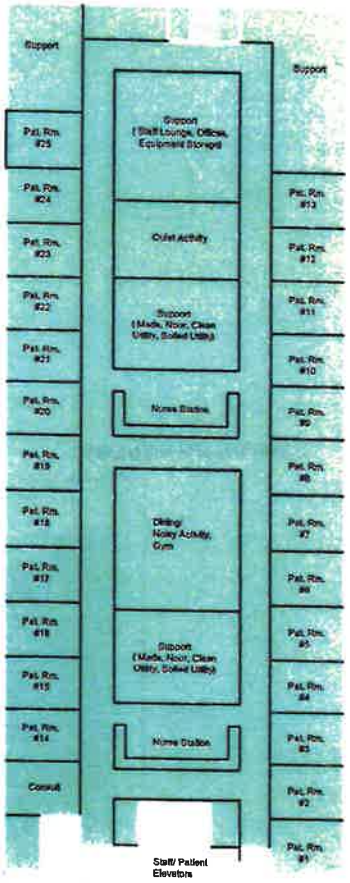
4 Fourth Floor

tmp

Skilled Nursing Unit

PROPOSED PLAN FOURTH FLOOR

28, 2014
8:35am



4 Fourth Floor

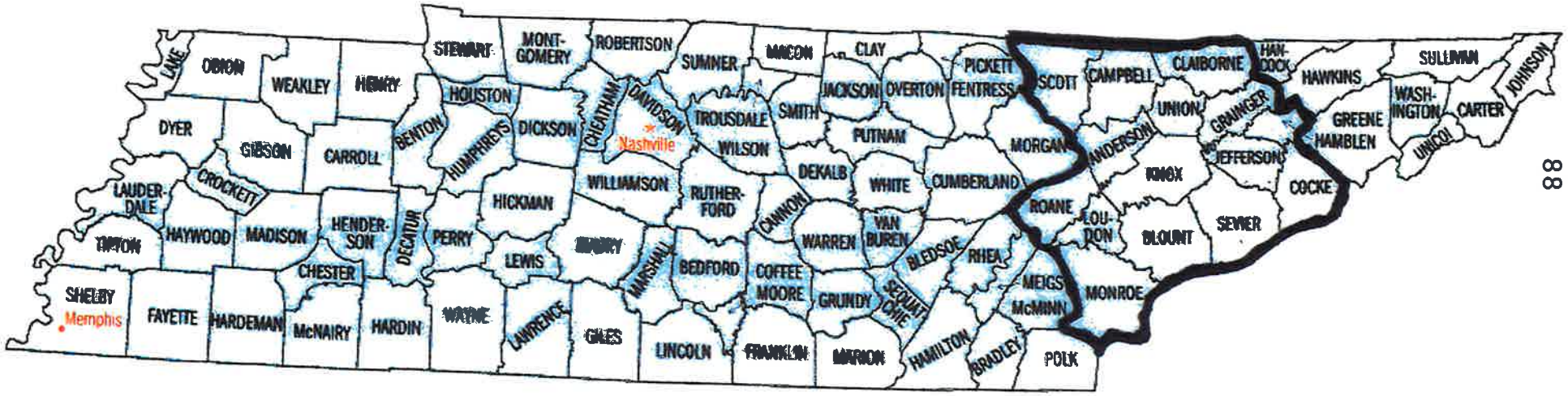
tmp

Skilled Nursing Unit

SUPPLEMENTAL- # 1

28, 2014
8:35am

Attachment C.Need.3


LAKE
OBION
WEAKLEY
HENRY
STEWART
MONT-GOMERY
ROBERTSON
SUMNER
MACON
CLAY
PICKETT
FENTRESS
SCOTT
CAMPBELL
CLAIBORNE
HAN-COCK
HAWKINS
SULLIVAN
JOHNSON
WASH-INGTON
CARTER
UNICOI
GREENE
HAMBLEN
GRAINGER
UNION
JEFFERSON
COCKE
SEVIER
BLOUNT
KNOX
ANDERSON
LOU-DON
MONROE
MEIGS
McMINN
RHEA
ROANE
MORGAN
OVERTON
JACKSON
SMITH
TROUSDALE
DAVIDSON
Nashville
CHEATHAM
DICKSON
HOUSTON
HUMPHREYS
BENTON
DYER
GIBSON
CARROLL
CROCKETT
LAUDER-DALE
TIPTON
HAYWOOD
MADISON
HENDER-SON
CHESTER
DECATUR
PERRY
HICKMAN
LEWIS
WILLIAMSON
RUTHER-FORD
CANNON
DEKALB
PUTNAM
WILSON
WHITE
CUMBERLAND
VAN BUREN
WARREN
BEDFORD
COFFEE
MOORE
GRUNDY
SEQUATCHIE
BLEDSOE
MARSHALL
SHELBY
Memphis
FAYETTE
HARDEMAN
McNAIRY
HARDIN
WAYNE
LAWRENCE
GILES
LINCOLN
FRANKLIN
MARION
HAMILTON
BRADLEY
POLK

88

Attachment C.Economic Feasibility.1

Construction Costs for Skilled Nursing Unit

Cost per square foot	**$**	**300**
Square feet		**19,650**
Construction cost - skilled nursing	**$**	**5,895,000**

M. J. HARRIS
CONSTRUCTION SERVICES, LLC

July 8, 2014

Physicians Regional Medical Center
c/o
Mr. Keith Kizzire
CHS Professional Services Corporation (CHSPSC)
4000 Meridian Blvd.
Franklin, TN 37067

RE: Conceptual Budget Proposal
Physicians Regional Medical Center
Replacement Hospital
Knoxville, Tennessee

Dear Mr. Kizzire:

M. J. Harris Construction Services, LLC is pleased to submit the attached Conceptual Budget Proposal for the above referenced project. This proposal is based on the CHS KPU Space Program Template dated January 30, 2014, C200 Preliminary Site Layout Plan without MOB prepared by Thomas, Miller & Partners, PLLC dated February 7, 2014, Report of Preliminary Subsurface Exploration prepared by Professional Engineers, Inc. dated May 24, 2013, and MEP Systems Narratives prepared by I. C. Thomasson Associates, Inc. dated January 28, 2014.

Please note builder's risk and performance and payment bonds are not included in the pricing.

Our price is based on today's material and labor values.

We appreciate the opportunity to work with Community Health Systems and the Physicians Regional Medical Center and look forward to a quality working relationship. If you have any questions, please contact me at (615) 727-0400.

Respectfully submitted,

Jennifer Johnson

Jenny Johnson
Senior Estimator

CC: File, Tommy Yeager, Michael Harris, and Garrett Barnes

5210 Maryland Way, Suite 101
Brentwood, TN 37027
phone 615.727.0400
fax 615.727.0401
www.mjharris.com

M. J. HARRIS
CONSTRUCTION SERVICES, LLC

Division Cost Breakdown

Conceptual Budget Proposal
Physicians Regional Medical Center
Replacement Hospital
Knoxville, TN

July 8, 2014

DIVISION	ITEM OF WORK	Quantity	Unit	Unit Price	TOTAL COST
1	General Requirements	22	MO	$ 70,000.00	$ 1,540,000
2	Sitework	70	AC	$ 172,134.79	$ 12,049,435
3	Concrete	556,083	SF	$ 17.13	$ 9,525,702
4	Masonry	556,083	SF	$ 5.80	$ 3,225,281
5	Metals	556,083	SF	$ 28.50	$ 15,848,366
6	Woods, Plastics, and Composites	556,083	SF	$ 3.85	$ 2,140,920
7	Thermal and Moisture Protection	556,083	SF	$ 10.93	$ 6,077,987
8	Openings	556,083	SF	$ 10.82	$ 6,016,818
9	Finishes	556,083	SF	$ 43.08	$ 23,956,056
10	Specialties	556,083	SF	$ 2.71	$ 1,506,985
11	Equipment	556,083	SF	$ 2.76	$ 1,534,789
12	Furnishings	556,083	SF	$ 0.42	$ 233,555
13	Special Construction	556,083	SF	$ 0.70	$ 389,258
14	Conveying Systems	556,083	SF	$ 2.11	$ 1,173,335
15	Mechanical	556,083	SF	$ 96.24	$ 53,517,428
16	Electrical	556,083	SF	$ 50.51	$ 28,088,985
	BASE BID:	**556,083**	**SF**	**$ 300.00**	**$166,824,900**
	M. J. Harris Construction Services, LLC				

M . J . H A R R I S
CONSTRUCTION SERVICES, LLC

COMMENTS & CLARIFICATIONS

Conceptual Budget Proposal
Physicians Regional Medical Center
Replacement Hospital
Knoxville, TN

July 8, 2014

INCLUSIONS

- 22 Month Project Duration

EXCLUSIONS

- Structured Cabling and Low Voltage Equipment & Devices
- Pneumatic Tube System
- Grave Relocation
- Escalation (Recommend 3-5% per Year)
- Payment & performance Bond
- Builder's Risk Insurance
- Remobilization (All Work Completed in One Mobilization)
- Hoisting of Owner Furnished Equipment
- Subguard / Bonding
- Tap & Impact Fees
- Contingency

5210 Maryland Way, Suite 101
Brentwood, TN 37027
phone 615.727.0400
fax 615.727.0401
www.mjharris.com

Attachment C.Economic Feasibility.2

Tennova™ Healthcare

August 27, 2014

Ms. Melanie Hill
Executive Director
Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

Dear Ms. Hill:

As CFO of Physicians Regional Medical Center, I am submitting this letter to confirm that the $6,454,796 required for the application to relocate 25 nursing home beds to the proposed replacement hospital for Physicians Regional Medical Center is available through the cash reserves of CHS/Community Health Systems, Inc., the parent of Knoxville HMA Holdings, LLC. The cost estimate for this project includes legal and administrative costs, construction costs, equipment costs, the cost of the land purchase, and a contingency fund.

Sincerely,

Rhonda Maynard

Rhonda Maynard
Chief Financial Officer

Attachment C.Economic Feasibility.6

7540 North 19th Avenue
Phoenix, Arizona 85021
(888) 873-4221
fax (888) 543-2289
www.SYNERTX.com

SYNERTX, a national provider of contract rehabilitation services and an industry leader in regulatory expertise, brings you the 2013 SNF Prospective Payment System (PPS) rates effective October 1, 2012.

2013 Prospective Payment System (PPS) RUG IV Rates Effective October 1, 2012
These rates are effective for Knox county in TN. (Wage Factor: 0.7575)

Rate Class	Payment Amount
RUX	$626.18
RUL	$612.53
RUC	$474.71
RUB	$474.71
RUA	$396.93
RVX	$557.34
RVL	$500.04
RVC	$407.25
RVB	$352.66
RVA	$351.30
RHX	$504.97
RHL	$450.39
RHC	$354.86
RHB	$319.39
RHA	$281.18
RMX	$463.21
RML	$425.00
RMC	$311.75
RMB	$292.64
RMA	$240.79
RLX	$406.80
RLB	$303.10
RLA	$195.30
ES3	$571.68
ES2	$447.51
ES1	$399.75
HE2	$386.10
HD2	$361.54
HC2	$341.08
HB2	$336.98
HE1	$320.61
HD1	$301.50
HC1	$285.13

Rate Class	Payment Amount
HB1	$282.40
LE2	$350.63
LD2	$336.98
LC2	$296.04
LB2	$281.03
LE1	$293.31
LD1	$282.40
LC1	$249.65
LB1	$238.73
CE2	$312.41
CD2	$296.04
CC2	$259.20
CB2	$240.10
CA2	$203.25
CE1	$287.86
CD1	$271.48
CC1	$240.10
CB1	$222.36
CA1	$189.61
BB2	$215.53
BA2	$178.70
BB1	$205.98
BA1	$170.50
PE2	$287.86
PD2	$271.48
PC2	$233.28
PB2	$197.80
PA2	$163.68
PE1	$274.21
PD1	$257.83
PC1	$222.36
PB1	$189.61
PA1	$156.86

SYNERTX makes no expressed or implied warranty on the accuracy of the calculated rates. Your use of these rates and the information it provides is therefore undertaken at your own risk, and you hereby agree to hold SYNERTX harmless for any losses or damages that may result from error or omission.

These rates are based on the Federal Register Vol. 77, No. 149 dated August 2, 2012 - Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2013; Notice.

The information provided should be verified by your own Accountant or Medicare Administrative Contractor (MAC) for accuracy.

Attachment C.Economic Feasibility.10

CHS/Community Health Systems, Inc.
(a wholly-owned subsidiary of Community Health Systems, Inc.) and Subsidiaries
Consolidated Financial Statements as of December 31, 2013 and 2012, and for the Years Ended December 31, 2013, 2012 and 2011 and Independent Auditors' Report

Table of Contents

CHS/Community Health Systems, Inc. (a wholly-owned subsidiary of Community Health Systems, Inc.) and Subsidiaries

Deloitte.

Deloitte & Touche LLP
Suite 2400
424 Church Street
Nashville, TN 37219
USA

Tel: +1 615 259 1800
www.deloitte.com

INDEPENDENT AUDITORS' REPORT

To the Board of Directors and Stockholder of
CHS/Community Health Systems, Inc.
Franklin, Tennessee

We have audited the accompanying consolidated financial statements of CHS/Community Health Systems, Inc. (a wholly-owned subsidiary of Community Health Systems, Inc.) and its subsidiaries (the "Company"), which comprise the consolidated balance sheets as of December 31, 2013 and 2012, and the related consolidated statements of income, comprehensive income, stockholder's equity, and cash flows for each of the three years in the period ended December 31, 2013, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditors' Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and in accordance with the auditing standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Company's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CHS/Community Health Systems, Inc. and its subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013, in accordance with accounting principles generally accepted in the United States of America.

Deloitte + Touche LLP

March 5, 2014

CHS/COMMUNITY HEALTH SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF COMMUNITY HEALTH SYSTEMS, INC.) AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2013	2012	2011
		(In thousands)	
Operating revenues (net of contractual allowances and discounts)	$ 15,078,074	$ 14,988,179	$ 13,626,168
Provision for bad debts	2,080,381	1,959,194	1,719,956
Net operating revenues	12,997,693	13,028,985	11,906,212
Operating costs and expenses:			
Salaries and benefits	6,217,747	6,103,931	5,577,925
Supplies	1,994,116	1,973,491	1,834,106
Other operating expenses	2,880,357	2,869,786	2,515,638
Government settlement and related costs	101,500	-	-
Electronic health records incentive reimbursement	(165,877)	(126,734)	(63,397)
Rent	287,412	272,829	254,781
Depreciation and amortization	782,675	725,558	652,674
Total operating costs and expenses	12,097,930	11,818,861	10,771,727
Income from operations	899,763	1,210,124	1,134,485
Interest expense, net of interest income of $2,977, $3,031 and $4,650 in 2013, 2012 and 2011, respectively	615,147	622,933	644,410
Loss from early extinguishment of debt	1,295	115,453	66,019
Equity in earnings of unconsolidated affiliates	(42,641)	(42,033)	(49,491)
Impairment of long-lived assets	20,100	10,000	-
Income from continuing operations before income taxes	305,862	503,771	473,547
Provision for income taxes	88,594	157,502	137,653
Income from continuing operations	217,268	346,269	335,894
Discontinued operations, net of taxes:			
Loss from operations of entities sold	-	(466)	(7,769)
Impairment of hospitals sold	-	-	(47,930)
Loss on sale, net	-	-	(2,572)
Loss from discontinued operations, net of taxes	-	(466)	(58,271)
Net income	217,268	345,803	277,623
Less: Net income attributable to noncontrolling interests	76,065	80,163	75,675
Net income attributable to CHS/Community Health Systems, Inc. stockholder	$ 141,203	$ 265,640	$ 201,948

See notes to the consolidated financial statements.

CHS/COMMUNITY HEALTH SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF COMMUNITY HEALTH SYSTEMS, INC.) AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Year Ended December 31,		
	2013	2012	2011
		(In thousands)	
Net income	$ 217,268	$ 345,803	$ 277,623
Other comprehensive income (loss), net of income taxes:			
Net change in fair value of interest rate swaps, net of tax of $33,875, $26,219 and $31,154 for the years ended December 31, 2013, 2012 and 2011, respectively	60,304	46,409	55,145
Net change in fair value of available-for-sale securities, net of tax	2,181	3,012	(960)
Amortization and recognition of unrecognized pension cost components, net of tax (benefit) of $9,140, $(3,310) and $(4,754) for the years ended December 31, 2013, 2012 and 2011, respectively	15,320	(10,252)	(7,737)
Other comprehensive income	77,805	39,169	46,448
Comprehensive income	295,073	384,972	324,071
Less: Comprehensive income attributable to noncontrolling interests	76,065	80,163	75,675
Comprehensive income attributable to CHS/Community Health Systems, Inc. stockholder	$ 219,008	$ 304,809	$ 248,396

See notes to the consolidated financial statements.

CHS/COMMUNITY HEALTH SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF COMMUNITY HEALTH SYSTEMS, INC.) AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS

	December 31, 2013	December 31, 2012
	(In thousands, except share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 373,403	$ 387,813
Patient accounts receivable, net of allowance for doubtful accounts of $2,448,432 and $2,201,875 at December 31, 2013 and 2012, respectively	2,353,308	2,067,379
Supplies	377,005	368,172
Prepaid income taxes	107,077	49,888
Deferred income taxes	101,372	117,045
Prepaid expenses and taxes	128,476	126,561
Other current assets	307,322	302,284
Total current assets	3,747,963	3,419,142
Property and equipment:		
Land and improvements	628,539	614,964
Buildings and improvements	6,302,739	6,086,169
Equipment and fixtures	3,675,472	3,444,275
Property and equipment, gross	10,606,750	10,145,408
Less accumulated depreciation and amortization	(3,492,287)	(2,993,535)
Property and equipment, net	7,114,463	7,151,873
Goodwill	4,444,135	4,408,138
Other assets, net of accumulated amortization of $535,142 and $394,827 at December 31, 2013 and 2012, respectively	1,810,734	1,627,182
Total assets	$ 17,117,295	$ 16,606,335
LIABILITIES AND EQUITY		
Current liabilities:		
Current maturities of long-term debt	$ 166,902	$ 89,911
Accounts payable	958,593	825,914
Deferred income taxes	3,183	-
Accrued liabilities:		
Employee compensation	698,987	713,685
Interest	111,891	110,702
Other	517,927	403,008
Total current liabilities	2,457,483	2,143,220
Long-term debt	9,286,495	9,451,394
Deferred income taxes	906,101	808,489
Other long-term liabilities	977,336	1,039,045
Total liabilities	13,627,415	13,442,148
Redeemable noncontrolling interests in equity of consolidated subsidiaries	358,410	367,666
Commitments and contingencies (Note 14)		
EQUITY		
CHS/Community Health Systems, Inc. stockholder's equity:		
Common stock, $.01 par value per share, 100,000 shares authorized	1	1
Additional paid-in capital	1,250,136	1,132,524
Accumulated other comprehensive loss	(67,505)	(145,310)
Retained earnings	1,885,195	1,743,992
Total CHS/Community Health Systems, Inc. stockholder's equity	3,067,827	2,731,207
Noncontrolling interests in equity of consolidated subsidiaries	63,643	65,314
Total equity	3,131,470	2,796,521
Total liabilities and equity	$ 17,117,295	$ 16,606,335

See notes to the consolidated financial statements.

CHS/COMMUNITY HEALTH SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF COMMUNITY HEALTH SYSTEMS, INC.) AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDER'S EQUITY

		CHS/Community Health Systems, Inc.						
	Redeemable Noncontrolling Interests	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Noncontrolling Interests	Total Equity
				(In thousands, except share data)				
Balance, December 31, 2010	$ 387,472	100,000	$ 1	$ 1,121,008	$ (230,927)	$ 1,299,382	$ 60,913	$ 2,250,377
Comprehensive income (loss)	54,251	-	-	-	46,448	201,948	21,424	269,820
Distributions to noncontrolling interests, net of contributions	(39,816)	-	-	-	-	-	(15,049)	(15,049)
Purchase of subsidiary shares from noncontrolling interests	(7,426)	-	-	(4,556)	-	-	(1,040)	(5,596)
Other reclassifications of noncontrolling interests	(2,099)	-	-	-	-	-	1,101	1,101
Adjustment to redemption value of redeemable noncontrolling interests	3,361	-	-	(3,361)	-	-	-	(3,361)
Distributions to Community Health Systems, Inc.	-			(32,847)	-	-	-	(32,847)
Balance, December 31, 2011	395,743	100,000	1	1,080,244	(184,479)	1,501,330	67,349	2,464,445
Comprehensive income	56,235	-	-	-	39,169	265,640	23,928	328,737
Distributions to noncontrolling interests, net of contributions	(43,613)	-	-	-	-	-	(24,196)	(24,196)
Purchase of subsidiary shares from noncontrolling interests	(21,607)	-	-	(21,537)	-	-	(1,143)	(22,680)
Other reclassifications of noncontrolling interests	718	-	-	-	-	-	(624)	(624)
Adjustment to redemption value of redeemable noncontrolling interests	(19,810)	-	-	19,810	-	-	-	19,810
Dividend to shareholder	-				-	(22,978)	-	(22,978)
Contributions from Community Health Systems, Inc.	-			54,007	-	-	-	54,007
Balance, December 31, 2012	367,666	100,000	1	1,132,524	(145,310)	1,743,992	65,314	2,796,521
Comprehensive income	50,624	-	-	-	77,805	141,203	25,441	244,449
Distributions to noncontrolling interests, net of contributions	(48,518)	-	-	-	-	-	(26,776)	(26,776)
Purchase of subsidiary shares from noncontrolling interests	(5,891)	-	-	(768)	-	-	(2,645)	(3,413)
Other reclassifications of noncontrolling interests	2,290	-	-	-	-	-	(2,290)	(2,290)
Noncontrolling interests in acquired entity	-	-	-	-	-	-	4,599	4,599
Adjustment to redemption value of redeemable noncontrolling interests	(7,761)	-	-	7,761	-	-	-	7,761
Contributions from Community Health Systems, Inc.	-			110,619	-	-	-	110,619
Balance, December 31, 2013	$ 358,410	100,000	$ 1	$ 1,250,136	$ (67,505)	$ 1,885,195	$ 63,643	$ 3,131,470

See notes to the consolidated financial statements.

CHS/COMMUNITY HEALTH SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF COMMUNITY HEALTH SYSTEMS, INC.) AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Cash flows from operating activities:			
Net income	$ 217,268	$ 345,803	$ 277,623
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	782,675	725,558	657,665
Deferred income taxes	69,284	53,407	107,032
Government settlement and related costs	101,500	-	-
Stock-based compensation expense	38,403	40,896	42,542
Loss on sale, net	-	-	2,572
Impairment of hospitals sold	-	-	47,930
Impairment of long-lived assets	20,100	10,000	-
Loss from early extinguishment of debt	1,295	115,453	66,019
Excess tax benefit relating to stock-based compensation	(6,715)	(3,973)	(5,290)
Other non-cash expenses, net	60,839	33,251	28,716
Changes in operating assets and liabilities, net of effects of acquisitions and divestitures:			
Patient accounts receivable	(285,437)	(204,151)	(138,332)
Supplies, prepaid expenses and other current assets	(8,453)	(99,799)	(42,858)
Accounts payable, accrued liabilities and income taxes	72,474	246,301	246,110
Other	25,486	17,374	(27,821)
Net cash provided by operating activities	1,088,719	1,280,120	1,261,908
Cash flows from investing activities:			
Acquisitions of facilities and other related equipment	(43,743)	(322,315)	(415,360)
Purchases of property and equipment	(613,992)	(768,790)	(776,713)
Proceeds from disposition of hospitals and other ancillary operations	-	-	173,387
Proceeds from sale of property and equipment	6,409	5,897	11,160
Increase in other investments	(339,942)	(297,994)	(188,249)
Net cash used in investing activities	(991,268)	(1,383,202)	(1,195,775)
Cash flows from financing activities:			
Capital distributions, net	75,346	15,517	(74,901)
Payment of special dividend to stockholder	-	(22,535)	-
Deferred financing costs	(13,199)	(141,219)	(19,352)
Proceeds from noncontrolling investors in joint ventures	289	535	1,229
Redemption of noncontrolling investments in joint ventures	(9,304)	(44,287)	(13,022)
Distributions to noncontrolling investors in joint ventures	(75,583)	(68,344)	(56,094)
Borrowings under credit agreements	1,194,575	3,975,866	578,236
Issuance of long-term debt	-	3,825,000	1,000,000
Proceeds from receivables facility	338,000	350,000	-
Repayments of long-term indebtedness	(1,621,985)	(7,529,503)	(1,651,533)
Net cash (used in) provided by financing activities	(111,861)	361,030	(235,437)
Net change in cash and cash equivalents	(14,410)	257,948	(169,304)
Cash and cash equivalents at beginning of period	387,813	129,865	299,169
Cash and cash equivalents at end of period	$ 373,403	$ 387,813	$ 129,865
Supplemental disclosure of cash flow information:			
Interest payments	$ 582,828	$ 594,292	$ 680,704
Income tax paid, net of refunds received	$ 72,794	$ 55,551	$ 26,463

See notes to the consolidated financial statements.

CHS/COMMUNITY HEALTH SYSTEMS, INC.
(A WHOLLY-OWNED SUBSIDIARY OF COMMUNITY HEALTH SYSTEMS, INC.) AND SUBSIDIARIES
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

1. BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

Business. CHS/Community Health Systems, Inc., a wholly-owned subsidiary of Community Health Systems, Inc. (the "Parent"), through its subsidiaries (collectively the "Company"), owns, leases and operates acute care hospitals in non-urban and selected urban markets. As of December 31, 2013, the Company owned or leased 135 hospitals, including four stand-alone rehabilitation or psychiatric hospitals, licensed for 20,180 beds in 29 states. Throughout these notes to the consolidated financial statements, CHS/Community Health Systems, Inc. and its consolidated subsidiaries are referred to on a collective basis as the "Company." This drafting style is not meant to indicate that the Company or any subsidiary of the Parent owns or operates any asset, business, or property. The hospitals, operations and businesses described in these consolidated financial statements are owned and operated, and management services provided, by distinct and indirect subsidiaries of CHS/Community Health Systems, Inc.

As of December 31, 2013, Texas, Pennsylvania and Indiana represent the only areas of geographic concentration. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Texas, as a percentage of consolidated operating revenues, were 14.8% in 2013, 14.4% in 2012 and 13.1% in 2011. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Pennsylvania, as a percentage of consolidated operating revenues, were 13.0% in 2013, 12.6% in 2012 and 11.5% in 2011. Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), generated by the Company's hospitals in Indiana, as a percentage of consolidated operating revenues, were 10.5% in 2013, 10.5% in 2012 and 10.3% in 2011.

Use of Estimates. The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America ("U.S. GAAP") requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates under different assumptions or conditions.

Principles of Consolidation. The consolidated financial statements include the accounts of the Company, its subsidiaries, all of which are controlled by the Company through majority voting control, and variable interest entities for which the Company is the primary beneficiary. All significant intercompany accounts, profits and transactions have been eliminated. Noncontrolling interests in less-than-wholly-owned consolidated subsidiaries of the Company are presented as a component of total equity to distinguish between the interests of the Company and the interests of the noncontrolling owners. Revenues, expenses and income from continuing operations from these subsidiaries are included in the consolidated amounts as presented on the consolidated statements of income, along with a net income measure that separately presents the amounts attributable to the controlling interests and the amounts attributable to the noncontrolling interests for each of the periods presented. Noncontrolling interests that are redeemable or may become redeemable at a fixed or determinable price at the option of the holder or upon the occurrence of an event outside of the control of the Company are presented in mezzanine equity on the consolidated balance sheets. The Parent operates for the sole purpose of supporting the operations of the Company and all expenses of the Parent are reflected as expenses of the Company.

Cost of Revenue. Substantially all of the Company's operating expenses are "cost of revenue" items. Operating costs that could be classified as general and administrative by the Company would include the Company's corporate office costs at its Franklin, Tennessee office, which were $180.8 million, $214.8 million and $183.4 million for the years ended December 31, 2013, 2012 and 2011, respectively. Included in these amounts is stock-based compensation of $38.4 million, $40.9 million and $42.5 million for the years ended December 31, 2013, 2012 and 2011, respectively.

Cash Equivalents. The Company considers highly liquid investments with original maturities of three months or less to be cash equivalents.

Supplies. Supplies, principally medical supplies, are stated at the lower of cost (first-in, first-out basis) or market.

Marketable Securities. The Company's marketable securities are classified as trading or available-for-sale. Available-for-sale securities are carried at fair value as determined by quoted market prices, with unrealized gains and losses reported as a separate component of stockholder's equity. Trading securities are reported at fair value with unrealized gains and losses included in earnings. Interest and dividends on securities classified as available-for-sale or trading are included in net operating revenues and were not material in all periods presented. Other comprehensive income (loss) included an unrealized gain of $2.2 million, an unrealized gain of $3.0 million and an unrealized loss of $1.0 million during the years ended December 31, 2013, 2012 and 2011, respectively, related to these available-for-sale securities.

Property and Equipment. Property and equipment are recorded at cost. Depreciation is recognized using the straight-line method over the estimated useful lives of the land and improvements (2 to 15 years; weighted-average useful life is 14 years), buildings and improvements (5 to 50 years; weighted-average useful life is 24 years) and equipment and fixtures (4 to 18 years; weighted-average useful life is 8 years). Costs capitalized as construction in progress were $231.8 million and $173.4 million at December 31, 2013 and 2012, respectively. Expenditures for renovations and other significant improvements are capitalized; however, maintenance and repairs which do not improve or extend the useful lives of the respective assets are charged to operations as incurred. Interest capitalized related to construction in progress was $10.5 million, $23.9 million and $21.4 million for the years ended December 31, 2013, 2012 and 2011, respectively. Purchases of property and equipment and internal use-software accrued in accounts payable and not yet paid were $141.6 million and $50.2 million at December 31, 2013 and 2012, respectively.

The Company also leases certain facilities and equipment under capital leases (see Note 9). Such assets are amortized on a straight-line basis over the lesser of the term of the lease or the remaining useful lives of the applicable assets.

Goodwill. Goodwill represents the excess of the fair value of the consideration conveyed in the acquisition over the fair value of net assets acquired. Goodwill arising from business combinations is not amortized. Goodwill is required to be evaluated for impairment at the same time every year and when an event occurs or circumstances change such that it is reasonably possible that an impairment may exist. The Company performs its annual testing of impairment for goodwill in the fourth quarter of each year.

Other Assets. Other assets consist of costs associated with the issuance of debt, which are included in interest expense over the life of the related debt using the effective interest method; the insurance recovery receivable from excess insurance carriers related to the Company's self-insured malpractice general liability and workers' compensation insurance liability; and costs to recruit physicians to the Company's markets, which are deferred and expensed over the term of the respective physician recruitment contract, generally three years, and included in amortization expense. Other assets also include capitalized internal-use software costs, which are expensed over the expected useful life, which is generally three years for routine software and eight to ten years for major software projects, and included in amortization expense.

Third-Party Reimbursement. Net patient service revenue is reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Operating revenues include amounts estimated by management to be reimbursable by Medicare and Medicaid under prospective payment systems, provisions of cost-reimbursement and other payment methods. Approximately 34.6%, 36.1% and 36.5% of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), for the years ended December 31, 2013, 2012 and 2011, respectively, are related to services rendered to patients covered by the Medicare and Medicaid programs. Revenues from Medicare outlier payments are included in the amounts received from Medicare and were approximately 0.46%, 0.45% and 0.42% of operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), for the years ended December 31, 2013, 2012 and 2011, respectively. In addition, the Company is reimbursed by non-governmental payors using a variety of payment methodologies. Amounts received by the Company for treatment of patients covered by such programs are generally less than the standard billing rates. The differences between the estimated program reimbursement rates and the standard billing rates are accounted for as contractual adjustments, which are deducted from gross revenues to arrive at operating revenues (net of contractual allowances and discounts). These net operating revenues are an estimate of the net realizable amount due from these payors. The process of estimating contractual allowances requires the Company to estimate the amount expected to be received based on payor contract provisions. The key assumption in this process is the estimated contractual reimbursement percentage, which is based on payor classification and historical paid claims data. Due to the complexities involved in these estimates, actual payments the Company receives could be different from the amounts it estimates and records. Final settlements under some of these programs are subject to adjustment based on administrative review and audit by third parties. Adjustments to previous program reimbursement estimates are accounted for as contractual allowance adjustments and reported in the periods that such adjustments become known.

Included in net operating revenues for the year ended December 31, 2012 is approximately $105.3 million of net operating revenues from an industry-wide settlement with the United States Department of Health and Human Services and Centers for Medicare and Medicaid Services, based on a claim that acute-care hospitals in the U.S. were underpaid from the Medicare inpatient prospective payment system in federal fiscal years 1999 through 2011. The underpayments resulted from calculations related to the rural floor budget neutrality adjustments implemented in connection with the Balanced Budget Act of 1997. During the year ended December 31, 2012, the Company received approximately $104.0 million of cash from this settlement. Also included in net operating revenues for the year ended December 31, 2012 is an unfavorable adjustment of approximately $21.0 million related to the revised Supplemental Security Income ratios issued for federal fiscal years 2006 through 2009 utilized for calculating Medicare Disproportionate Share Hospital reimbursements. Other than these items, contractual allowance adjustments related to final settlements and previous program reimbursement estimates impacted net operating revenues and net income by an insignificant amount in each of the years ended December 31, 2013, 2012 and 2011.

Amounts due to third-party payors were $60.5 million and $80.5 million as of December 31, 2013 and 2012, respectively, and are included in accrued liabilities-other in the accompanying consolidated balance sheets. Amounts due from third-party payors were $118.0 million and $119.2 million as of December 31, 2013 and 2012, respectively, and are included in other current assets in the accompanying consolidated balance sheets. Substantially all Medicare and Medicaid cost reports are final settled through 2008.

Net Operating Revenues. Net operating revenues are recorded net of provisions for contractual allowance of approximately $53.4 billion, $49.3 billion and $42.4 billion in 2013, 2012 and 2011, respectively. Net operating revenues are recognized when services are provided and are reported at the estimated net realizable amount from patients, third-party payors and others for services rendered. Also included in the provision for contractual allowance shown above is the value of administrative and other discounts provided to self-pay patients eliminated from net operating revenues which was $1.4 billion, $1.2 billion and $852.4 million for the years ended December 31, 2013, 2012 and 2011, respectively.

In the ordinary course of business, the Company renders services to patients who are financially unable to pay for hospital care. The Company's policy is to not pursue collections for such amounts, therefore, the related charges for those patients who are financially unable to pay and that otherwise do not qualify for reimbursement from a governmental program are not reported in net operating revenues or in the provision for bad debts, and are thus classified as charity care. The Company determines amounts that qualify for charity care primarily based on the patient's household income relative to the federal poverty level guidelines, as established by the federal government.

Included in the provision for contractual allowance shown above is $703.3 million, $692.4 million and $651.1 million for the years ended December 31, 2013, 2012 and 2011, respectively, representing the value (at the Company's standard charges) of these charity care services that are excluded from net operating revenues.

The estimated cost incurred by the Company to provide these charity care services to patients who are unable to pay was approximately $120.8 million, $125.4 million and $125.7 million for the years ended December 31, 2013, 2012 and 2011, respectively. The estimated cost of these charity care services was determined using a ratio of cost to gross charges and applying that ratio to the gross charges associated with providing care to charity patients for the period.

Currently, several states utilize supplemental reimbursement programs for the purpose of providing reimbursement to providers to offset a portion of the cost of providing care to Medicaid patients. These programs are designed with input from Centers for Medicare and Medicaid Services and are funded with a combination of state and federal resources, including, in certain instances, fees or taxes levied on the providers. Similar programs are also being considered by other states. After these supplemental programs are signed into law, the Company recognizes revenue and related expenses in the period in which amounts are estimable and collection is reasonably assured. Reimbursement under these programs is reflected in net operating revenues and fees, taxes or other program-related costs are reflected in other operating expenses.

Operating revenues, net of contractual allowances and discounts (but before the provision for bad debts), recognized during the years ended December 31, 2013, 2012 and 2011, were as follows (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Medicare	$ 3,750,696	$ 3,955,235	$ 3,654,247
Medicaid	1,468,717	1,455,650	1,318,756
Managed Care and other third-party payors	7,797,495	7,629,416	7,014,519
Self-pay	2,061,166	1,947,878	1,638,646
Total	$ 15,078,074	$ 14,988,179	$ 13,626,168

Allowance for Doubtful Accounts. Accounts receivable are reduced by an allowance for amounts that could become uncollectible in the future. Substantially all of the Company's receivables are related to providing healthcare services to its hospitals' patients.

The Company estimates the allowance for doubtful accounts by reserving a percentage of all self-pay accounts receivable without regard to aging category, based on collection history, adjusted for expected recoveries and, if present, anticipated changes in trends. For all other non-self-pay payor categories, the Company reserves 100% of all accounts aging over 365 days from the date of discharge. The percentage used to reserve for all self-pay accounts is based on the Company's collection history. The Company collects substantially all of its third-party insured receivables, which include receivables from governmental agencies.

Collections are impacted by the economic ability of patients to pay and the effectiveness of the Company's collection efforts. Significant changes in payor mix, business office operations, economic conditions or trends in federal and state governmental healthcare coverage could affect the Company's collection of accounts receivable and the estimates of the collectability of future accounts receivable. The process of estimating the allowance for doubtful accounts requires the Company to estimate the collectability of self-pay accounts receivable, which is primarily based on its collection history, adjusted for expected recoveries and, if present, anticipated changes in collection trends. The Company also continually reviews its overall reserve adequacy by monitoring historical cash collections as a percentage of trailing net revenue less provision for bad debts, as well as by analyzing current period net revenue and admissions by payor classification, aged accounts receivable by payor, days revenue outstanding, and the impact of recent acquisitions and dispositions.

Electronic Health Records Incentive Reimbursement. The American Recovery and Reinvestment Act of 2009 included provisions for implementing health information technology under the Health Information Technology for Economic and Clinical Health Act ("HITECH"). These provisions were designed to increase the use of electronic health records ("EHR") technology and establish the requirements for a Medicare and Medicaid incentive payments program beginning in 2011 for eligible hospitals and providers that adopt and meaningfully use certified EHR technology. The Company utilizes a gain contingency model to recognize EHR incentive payments. Recognition occurs when our eligible hospitals adopt or demonstrate meaningful use of certified EHR technology for the applicable payment period and have available the Medicare cost report information for the relevant full cost report year used to determine the final incentive payment.

Medicaid EHR incentive payments are calculated based on prior period Medicare cost report information available at the time when eligible hospitals adopt, implement or demonstrate meaningful use of certified EHR technology. Since the information for the relevant full Medicare cost report year is available, the incentive income from resolving the gain contingency is recognized when eligible hospitals adopt, implement or demonstrate meaningful use of certified EHR technology.

Medicare EHR incentive payments are calculated based on the Medicare cost report information for the full cost report year that began during the federal fiscal year in which meaningful use is demonstrated. Since the necessary information is only available at the end of the relevant full Medicare cost report year, the incentive income from resolving the gain contingency is recognized when eligible hospitals demonstrate meaningful use of certified EHR technology and the information for the applicable full Medicare cost report year to determine the final incentive payment is available.

In some instances, the Company may receive estimated Medicare EHR incentive payments prior to when the Medicare cost report information used to determine the final incentive payment is available. In these instances, recognition of the gain for EHR incentive payments is deferred until all recognition criteria described above are met.

Eligibility for annual Medicare incentive payments is dependent on providers demonstrating meaningful use of EHR technology. Initial Medicaid incentive payments were available to providers that adopt, implement or upgrade certified EHR technology; however, providers must demonstrate meaningful use of such technology in subsequent years to qualify for additional incentive payments. Medicaid EHR incentive payments are fully funded by the federal government and administered by the states; however, the states are not required to offer EHR incentive payments to providers.

The Company recognized approximately $165.9 million, $126.7 million and $63.4 million during the years ended December 31, 2013, 2012 and 2011, respectively, of incentive reimbursement for HITECH incentives from Medicare and Medicaid related to certain of the Company's hospitals and for certain of the Company's employed physicians that have demonstrated meaningful use of certified EHR technology or have completed attestations to their adoption or implementation of certified EHR technology. These incentive reimbursements are presented as a reduction of operating costs and expenses on the consolidated statements of income. The Company received cash related to the incentive reimbursement for HITECH incentives of approximately $203.1 million, $141.0 million and $37.4 million during the years ended December 31, 2013, 2012 and 2011, respectively. As of December 31, 2013 and 2012, $90.2 million and $33.3 million, respectively, were recorded as deferred revenue as all criteria for gain recognition had not been met.

Physician Income Guarantees. The Company enters into physician recruiting agreements under which it supplements physician income to a minimum amount over a period of time, typically one year, while the physicians establish themselves in the community. As part of the agreements, the physicians are committed to practice in the community for a period of time, typically three years, which extends beyond their income guarantee period. The Company records an asset and liability for the estimated fair value of minimum revenue guarantees on new agreements. Adjustments to the ultimate value of the guarantee paid to physicians are recognized in the period that the change in estimate is identified. The Company amortizes an asset over the life of the agreement. As of December 31, 2013 and 2012, the unamortized portion of these physician income guarantees was $33.0 million and $30.1 million, respectively.

Concentrations of Credit Risk. The Company grants unsecured credit to its patients, most of whom reside in the service area of the Company's facilities and are insured under third-party payor agreements. Because of the economic diversity of the Company's facilities and non-governmental third-party payors, Medicare represents the only significant concentration of credit risk from payors. Accounts receivable, net of contractual allowances, from Medicare were $359.6 million and $315.5 million as of December 31, 2013 and 2012, respectively, representing 7.5% and 7.4% of consolidated net accounts receivable, before allowance for doubtful accounts, as of December 31, 2013 and 2012, respectively.

Professional Liability Claims. The Company accrues for estimated losses resulting from professional liability. The accrual, which includes an estimate for incurred but not reported claims, is based on historical loss patterns and actuarially-determined projections and is discounted to its net present value. To the extent that subsequent claims information varies from management's estimates, the liability is adjusted when such information becomes available.

Accounting for the Impairment or Disposal of Long-Lived Assets. Whenever events or changes in circumstances indicate that the carrying values of certain long-lived assets may be impaired, the Company projects the undiscounted cash flows expected to be generated by these assets. If the projections indicate that the reported amounts are not expected to be recovered, such amounts are reduced to their estimated fair value based on a quoted market price, if available, or an estimate based on valuation techniques available in the circumstances.

During the year ended December 31, 2013, the Company recorded a pretax impairment charge of $20.1 million to reduce the carrying value of certain long-lived assets at five of its smaller hospitals to their estimated fair value. During the year ended December 31, 2012, the Company recorded a pretax impairment charge of $10.0 million to reduce the carrying value of certain long-lived assets at three of its smaller hospitals to their estimated fair value. The impairments for 2013 and 2012 were identified because of declining operating results and projections of future cash flows at these hospitals caused by competitive and operational challenges specific to the markets in which these hospitals operate. There were no impairments of long-lived assets in 2011.

Income Taxes. The Company accounts for income taxes under the asset and liability method, in which deferred income tax assets and liabilities are recognized for the tax consequences of "temporary differences" by applying enacted statutory tax rates applicable to future years to differences between the financial statement carrying amounts and the tax bases of existing assets and liabilities. The effect on deferred taxes of a change in tax rates is recognized in the consolidated statement of income during the period in which the tax rate change becomes law.

Comprehensive Income (Loss). Comprehensive income (loss) is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources.

Accumulated Other Comprehensive Income (Loss) consisted of the following (in thousands):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2011	$ (162,791)	$ 1,576	$ (23,264)	$ (184,479)
2012 activity, net of tax	46,409	3,012	(10,252)	39,169
Balance as of December 31, 2012	(116,382)	4,588	(33,516)	(145,310)
2013 activity, net of tax	60,304	2,181	15,320	77,805
Balance as of December 31, 2013	$ (56,078)	$ 6,769	$ (18,196)	$ (67,505)

Derivative Instruments and Hedging Activities. The Company records derivative instruments on the consolidated balance sheet as either an asset or liability measured at its fair value. Changes in a derivative's fair value are recorded each period in earnings or other comprehensive income ("OCI"), depending on whether the derivative is designated and is effective as a hedged transaction, and on the type of hedge transaction. Changes in the fair value of derivative instruments recorded to OCI are reclassified to earnings in the period affected by the underlying hedged item. Any portion of the fair value of a derivative instrument determined to be ineffective under the standard is recognized in current earnings.

The Company has entered into several interest rate swap agreements. See Note 7 for further discussion about the swap transactions.

New Accounting Pronouncements. In February 2013, the Financial Accounting Standards Board issued Accounting Standards Update ("ASU") 2013-02, which requires additional disclosures on the effect of significant reclassifications out of accumulated other comprehensive income. The ASU requires a company that reports other comprehensive income to present (either on the face of the statement where net income is presented or in the notes) the effects on the line items of net income of significant amounts reclassified out of accumulated other comprehensive income. For other amounts that are not required to be reclassified in their entirety to net income in the same reporting period, an entity is required to cross-reference to other required disclosures that provide additional details about those amounts. This ASU is effective for fiscal years beginning after December 15, 2012, and was adopted by the Company on January 1, 2013. As it only requires additional disclosure, the adoption of this ASU had no impact on the Company's consolidated financial position, results of operations or cash flows.

2. ACCOUNTING FOR STOCK-BASED COMPENSATION

Along with the outside directors of the Parent, certain employees of the Company's subsidiaries receive compensation in the form of its Parent's equity through stock option and restricted stock grants of the Parent's stock. This Parent stock-based compensation is accounted for as if it is equity in the Company. Accordingly, stock-based compensation is included in salaries and benefits in the accompanying consolidated statements of income and in capital (distributions) contributions, net from the Parent in the accompanying consolidated statements of stockholder's equity and in the accompanying consolidated statements of cash flows.

Stock-based compensation awards have been granted under the Community Health Systems, Inc. Amended and Restated 2000 Stock Option and Award Plan, amended and restated as of March 20, 2013 (the "2000 Plan"), and the Community Health Systems, Inc. 2009 Stock Option and Award Plan, amended and restated as of March 20, 2013 (the "2009 Plan").

The 2000 Plan allowed for the grant of incentive stock options intended to qualify under Section 422 of the Internal Revenue Code (the "IRC"), as well as stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Prior to being amended in 2009, the 2000 Plan also allowed for the grant of phantom stock. Persons eligible to receive grants under the 2000 Plan include outside directors of the Parent and the Company's directors, officers, employees and consultants. All options granted under the 2000 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted prior to 2005 have a 10-year contractual term, options granted in 2005 through 2007 have an eight-year contractual term and options granted in 2008 through 2011 have a 10-year contractual term. The Company has not granted stock option awards under the 2000 Plan since 2011. Since the Company's stockholders approved the March 20, 2013 amendment and restatement of the 2009 Plan, no further grants will be awarded under the 2000 Plan.

The 2009 Plan provides for the grant of incentive stock options intended to qualify under Section 422 of the IRC and for the grant of stock options which do not so qualify, stock appreciation rights, restricted stock, restricted stock units, performance-based shares or units and other share awards. Persons eligible to receive grants under the 2009 Plan include outside directors of the Parent and the Company's directors, officers, employees and consultants. To date, all options granted under the 2009 Plan have been "nonqualified" stock options for tax purposes. Generally, vesting of these granted options occurs in one-third increments on each of the first three anniversaries of the award date. Options granted in 2011 or later have a 10-year contractual term. As of December 31, 2013, 4,160,962 shares of unissued common stock of the Parent were reserved for future grants under the 2009 Plan.

The exercise price of all options granted is equal to the fair value of the Parent's common stock on the option grant date.

The following table reflects the impact of total compensation expense related to stock-based equity plans on the reported operating results for the respective periods (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Effect on income from continuing operations before income taxes	$ (38,403)	$ (40,896)	$ (42,542)
Effect on net income	$ (24,040)	$ (25,683)	$ (27,014)

At December 31, 2013, $30.5 million of unrecognized stock-based compensation expense was expected to be recognized over a weighted-average period of 22 months. Of that amount, $1.7 million related to outstanding unvested stock options was expected to be recognized over a weighted-average period of 9 months and $28.8 million related to outstanding unvested restricted stock and restricted stock units was expected to be recognized over a weighted-average period of 23 months. There were no modifications to awards during the years ended December 31, 2013, 2012 and 2011.

The fair value of stock options granted during the years ended December 31, 2013, 2012 and 2011 was estimated using the Black Scholes option pricing model with the following assumptions:

	Year Ended December 31,		
	2013	2012	2011
Expected volatility	N/A	57.8 %	33.8 %
Expected dividends	N/A	-	-
Expected term	N/A	4.1 years	4 years
Risk-free interest rate	N/A	0.66 %	1.63 %

In determining the expected term, the Company examined concentrations of option holdings and historical patterns of option exercises and forfeitures, as well as forward-looking factors, in an effort to determine if there were any discernible employee populations. From this analysis, the Company identified two primary employee populations, one consisting of certain senior executives and the other one consisting of substantially all other recipients.

The expected volatility rate was estimated based on historical volatility. In determining expected volatility, the Company also reviewed the market-based implied volatility of actively traded options of the Parent's common stock and determined that historical volatility utilized to estimate the expected volatility rate did not differ significantly from the implied volatility.

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The expected term computation is based on historical exercise and cancellation patterns and forward-looking factors, where present, for each population identified. The risk-free interest rate is based on the U.S. Treasury yield curve in effect at the time of the grant. The pre-vesting forfeiture rate is based on historical rates and forward-looking factors for each population identified. The Company adjusts the estimated forfeiture rate to its actual experience.

Options outstanding and exercisable under the 2000 Plan and the 2009 Plan as of December 31, 2013, and changes during each of the years in the three-year period prior to December 31, 2013, were as follows (in thousands, except share and per share data):

	Shares	Weighted-Average Exercise Price	Weighted-Average Remaining Contractual Term	Aggregate Intrinsic Value as of December 31, 2013
Outstanding at December 31, 2010	7,834,332	$ 32.08		
Granted	1,505,000	35.87		
Exercised	(623,341)	30.34		
Forfeited and cancelled	(326,849)	33.69		
Outstanding at December 31, 2011	8,389,142	32.83		
Granted	253,500	21.16		
Exercised	(1,050,772)	19.85		
Forfeited and cancelled	(487,757)	34.12		
Outstanding at December 31, 2012	7,104,113	34.25		
Granted	-	-		
Exercised	(3,299,859)	33.53		
Forfeited and cancelled	(66,709)	34.01		
Outstanding at December 31, 2013	3,737,545	$ 34.88	4.1 years	$ 17,806
Exercisable at December 31, 2013	3,203,520	$ 35.49	3.5 years	$ 13,515

The weighted-average grant date fair value of stock options granted during the years ended December 31, 2012 and 2011, was $9.20 and $10.07, respectively. The aggregate intrinsic value (the number of in-the-money stock options multiplied by the difference between the Parent's closing stock price on the last trading day of the reporting period ($39.27) and the exercise price of the respective stock options) in the table above represents the amount that would have been received by the option holders had all option holders exercised their options on December 31, 2013. This amount changes based on the market value of the Parent's common stock. The aggregate intrinsic value of options exercised during the years ended December 31, 2013, 2012 and 2011 was $31.0 million, $9.4 million and $6.1 million, respectively. The aggregate intrinsic value of options vested and expected to vest approximates that of the outstanding options.

Restricted stock has also been awarded under the 2000 Plan and the 2009 Plan to outside directors of the Parent and employees of certain of its subsidiaries. The restrictions on these shares generally lapse in one-third increments on each of the first three anniversaries of the award date. Certain of the restricted stock awards granted to the Company's senior executives contain a performance objective that must be met in addition to any vesting requirements. If the performance objective is not attained, the awards will be forfeited in their entirety. Once the performance objective has been attained, restrictions will lapse in one-third increments on each of the first three anniversaries of the award date. Notwithstanding the above-mentioned performance objectives and vesting requirements, the restrictions will lapse earlier in the event of death, disability or termination of employment by the Company for any reason other than for cause of the holder of the restricted stock, or change in control of the Parent.

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Restricted stock outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2013, and changes during each of the years in the three-year period prior to December 31, 2013, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2010	2,125,291	$ 27.92
Granted	1,109,949	37.57
Vested	(1,009,959)	27.40
Forfeited	(17,669)	35.68
Unvested at December 31, 2011	2,207,612	32.95
Granted	680,500	21.20
Vested	(1,118,213)	29.67
Forfeited	(25,335)	30.94
Unvested at December 31, 2012	1,744,564	30.50
Granted	836,088	41.55
Vested	(945,894)	32.22
Forfeited	(27,269)	37.09
Unvested at December 31, 2013	1,607,489	35.13

Restricted stock units ("RSUs") have been granted to the Parent's outside directors under the 2000 Plan and the 2009 Plan. On February 23, 2011, each of the Parent's outside directors received a grant under the 2009 Plan of 3,688 RSUs. On February 16, 2012, each of the Parent's outside directors received a grant under the 2009 Plan of 6,645 RSUs. On February 27, 2013, each of the Parent's outside directors received a grant under the 2009 Plan of 3,596 RSUs. Vesting of these shares of RSUs occurs in one-third increments on each of the first three anniversaries of the award date.

RSUs outstanding under the 2000 Plan and the 2009 Plan as of December 31, 2013, and changes during each of the years in the three-year period prior to December 31, 2013, were as follows:

	Shares	Weighted-Average Grant Date Fair Value
Unvested at December 31, 2010	53,388	$ 26.11
Granted	22,128	37.96
Vested	(22,560)	24.68
Forfeited	-	-
Unvested at December 31, 2011	52,956	31.67
Granted	39,870	21.07
Vested	(29,940)	27.95
Forfeited	-	-
Unvested at December 31, 2012	62,886	26.72
Granted	21,576	41.71
Vested	(28,926)	29.04
Forfeited	-	-
Unvested at December 31, 2013	55,536	31.33

Under the Directors' Fees Deferral Plan, the Parent's outside directors may elect to receive share equivalent units in lieu of cash for their directors' fees. These share equivalent units are held in the plan until the director electing to receive the share equivalent units retires or otherwise terminates his/her directorship with the Parent. Share equivalent units are converted to shares of common stock of the Parent at the time of distribution based on the closing market price of the Parent's common stock on that date. The following table represents the amount of directors' fees which were deferred during each of the respective periods, and the number of share equivalent units into which such directors' fees would have converted had each of the directors who had deferred such fees retired or terminated his/her directorship with the Parent as of the end of the respective periods (in thousands, except share equivalent units):

	Year Ended December 31,		
	2013	2012	2011
Directors' fees earned and deferred into plan	$ 130	$ 110	$ 220
Share equivalent units	2,990	4,056	9,974

At December 31, 2013, a total of 31,059 share equivalent units were deferred in the plan with an aggregate fair value of $1.2 million, based on the closing market price of the Parent's common stock at December 31, 2013 of $39.27.

3. ACQUISITIONS AND DIVESTITURES

Acquisitions

The Company accounts for all transactions that represent business combinations using the acquisition method of accounting, where the identifiable assets acquired, the liabilities assumed and any noncontrolling interest in the acquired entity are recognized and measured at their fair values on the date the Company obtains control in the acquiree. Such fair values that are not finalized for reporting periods following the acquisition date are estimated and recorded as provisional amounts. Adjustments to these provisional amounts during the measurement period (defined as the date through which all information required to identify and measure the consideration transferred, the assets acquired, the liabilities assumed and any noncontrolling interests has been obtained, limited to one year from the acquisition date) are recorded as of the date of acquisition. Any material impact to comparative information for periods after acquisition, but before the period in which adjustments are identified, is reflected in those prior periods as if the adjustments were considered as of the acquisition date. Goodwill is determined as the excess of the fair value of the consideration conveyed in the acquisition over the fair value of the net assets acquired.

Effective July 1, 2012, one or more subsidiaries of the Company completed the acquisition of Memorial Health Systems in York, Pennsylvania. This healthcare system includes Memorial Hospital (100 licensed beds), the Surgical Center of York, and other outpatient and ancillary services. As part of this purchase agreement, the Company has agreed to spend at least $75.0 million to build a replacement hospital within five years of the closing date. The total cash consideration paid for fixed assets and working capital was approximately $45.0 million and $2.6 million, respectively, with additional consideration of $12.5 million assumed in liabilities, for a total consideration of $60.1 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2013, approximately $10.9 million of goodwill has been recorded.

Effective March 5, 2012, one or more subsidiaries of the Company completed a merger with Diagnostic Clinic of Longview, P.A., which is a multi-specialty clinic serving residents of Longview, Texas and surrounding East Texas communities. This merger was accounted for as a purchase business combination. The total cash consideration paid for the business, including net working capital, was approximately $52.3 million, with additional consideration of $6.9 million assumed in liabilities, for a total consideration of $59.2 million. Based upon the Company's final purchase price allocation relating to this acquisition, approximately $41.8 million of goodwill has been recorded.

Effective March 1, 2012, one or more subsidiaries of the Company completed the acquisition of MetroSouth Medical Center (330 licensed beds) located in Blue Island, Illinois. The total cash consideration paid for fixed assets was approximately $39.3 million with additional consideration of $5.8 million assumed in liabilities as well as a credit applied at closing of $0.9 million for negative acquired working capital, for a total consideration of $44.2 million. Based upon the Company's final purchase price allocation relating to this acquisition as of December 31, 2013, no goodwill has been recorded.

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Effective January 1, 2012, one or more subsidiaries of the Company completed the acquisition of Moses Taylor Healthcare System based in Scranton, Pennsylvania, which is a healthcare system comprised of two acute care hospitals and other healthcare providers. This healthcare system includes Moses Taylor Hospital (217 licensed beds) located in Scranton, Pennsylvania, and Mid-Valley Hospital (25 licensed beds) located in Peckville, Pennsylvania. The total cash consideration paid for fixed assets and working capital was approximately $151.1 million and $13.1 million, respectively, with additional consideration of $9.4 million assumed in liabilities, for a total consideration of $173.6 million. Based upon the Company's final purchase price allocation relating to this acquisition, approximately $54.6 million of goodwill has been recorded.

Effective October 1, 2011, one or more subsidiaries of the Company completed the acquisition of Tomball Regional Hospital (358 licensed beds) located in Tomball, Texas. The total cash consideration paid for fixed assets and working capital was approximately $192.0 million and $17.5 million, respectively, with additional consideration of $15.9 million assumed in liabilities, for a total consideration of $225.4 million. Based upon the Company's final purchase price allocation relating to this acquisition, as of December 31, 2013, approximately $32.4 million of goodwill has been recorded.

Effective May 1, 2011, one or more subsidiaries of the Company completed the acquisition of Mercy Health Partners based in Scranton, Pennsylvania, which is a healthcare system comprised of two acute care hospitals, a long-term acute care facility and other healthcare providers. This healthcare system includes Regional Hospital of Scranton (198 licensed beds) located in Scranton, Pennsylvania, and Tyler Memorial Hospital (48 licensed beds) located in Tunkhannock, Pennsylvania. This healthcare system also includes a long-term acute care facility, Special Care Hospital (67 licensed beds) located in Nanticoke, Pennsylvania, as well as several outpatient clinics and other ancillary facilities. The total cash consideration paid for fixed assets was approximately $150.8 million, with additional consideration of $12.3 million assumed in liabilities as well as a credit applied at closing of $2.1 million for negative acquired working capital, for a total consideration of $161.0 million. Based upon the Company's final purchase price allocation relating to this acquisition, as of December 31, 2013, approximately $43.1 million of goodwill has been recorded.

Approximately $20.6 million, $9.9 million and $16.0 million of acquisition costs related to prospective and closed acquisitions were expensed during the years ended December 31, 2013, 2012 and 2011, respectively, and are included in other operating expenses on the consolidated statements of income. For the year ended December 31, 2013, these acquisition costs included $14.1 million of expenses related to the acquisition of Health Management Associates, Inc. ("HMA").

The table below summarizes the allocations of the purchase price (including assumed liabilities) for the above hospital acquisition transactions in 2012 (in thousands) and reflects the fact that there were no hospital acquisitions in 2013:

	2013	2012
Current assets	N/A	$ 46,207
Property and equipment	N/A	178,836
Goodwill	N/A	106,269
Intangible assets	N/A	2,522
Other long-term assets	N/A	490
Liabilities	N/A	34,463

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The operating results of the foregoing transactions have been included in the accompanying consolidated statements of income from their respective dates of acquisition, including net operating revenues of $337.0 million for the year ended December 31, 2012 from hospital acquisitions that closed during 2012. The following pro forma combined summary of operations of the Company gives effect to using historical information of the operations of the hospital acquisitions in 2012 discussed above as if the transactions had occurred as of January 1, 2012 (in thousands):

	Year Ended December 31,	
	2013	2012 (Unaudited)
Pro forma net operating revenues	$ 12,997,693	$ 13,120,413
Pro forma net income	$ 217,268	$ 258,019

There were no hospital acquisitions in 2013, so the pro forma summarized operating results for the year ended December 31, 2013 equal the operating results as reported. Pro forma adjustments to net income include adjustments to depreciation and amortization expense, net of the related tax effect, based on the estimated fair value assigned to the long-lived assets acquired, and to interest expense, net of the related tax effect, assuming the increase in long-term debt used to fund the acquisitions had occurred as of January 1, 2012. These pro forma results are not necessarily indicative of the actual results of operations.

Additionally, during the years ended December 31, 2013, 2012 and 2011, the Company paid approximately $39.7 million, $41.5 million and $57.9 million, respectively, to acquire the operating assets and related businesses of certain physician practices, clinics and other ancillary businesses that operate within the communities served by its hospitals. In connection with these acquisitions, during 2013, the Company assumed approximately $4.6 million of noncontrolling interests and allocated approximately $8.9 million of the consideration paid to property and equipment, approximately $0.3 million to net working capital and the remainder, approximately $36.2 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. During 2012, the Company assumed approximately $2.0 million in net working capital liabilities and allocated approximately $10.2 million of the consideration paid to property and equipment and the remainder, approximately $33.3 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. During 2011, the Company allocated approximately $13.1 million of the consideration paid to property and equipment, $2.9 million to net working capital, $1.6 million to other intangible assets and the remainder, approximately $40.3 million consisting of intangible assets that do not qualify for separate recognition, to goodwill. These acquisition transactions during the years ended December 31, 2013, 2012 and 2011 were accounted for as purchase business combinations.

Discontinued Operations

Effective February 1, 2011, the Company sold Willamette Community Medical Group, which is a physician clinic operating as Oregon Medical Group, located in Springfield, Oregon, to Oregon Healthcare Resources, LLC, for $14.6 million in cash; this business had a carrying amount of net assets, including an allocation of reporting unit goodwill, of $19.7 million.

Effective September 1, 2011, the Company sold SouthCrest Hospital, located in Tulsa, Oklahoma, Claremore Regional Hospital, located in Claremore, Oklahoma, and other related healthcare assets affiliated with those hospitals to Hillcrest Healthcare System, part of Ardent Health Services, for approximately $154.2 million in cash. The carrying amount of the net assets sold in this transaction, including an allocation of reporting unit goodwill, was approximately $193.0 million.

Effective October 22, 2011, the Company sold Cleveland Regional Medical Center, located in Cleveland, Texas, and other related healthcare assets affiliated with the hospital to New Directions Health Systems, LLC for approximately $0.9 million in cash. The carrying amount of the net assets sold in this transaction, including an allocation of reporting unit goodwill, was approximately $14.2 million.

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The Company has classified the results of operations for Oregon Medical Group, SouthCrest Hospital, Claremore Regional Hospital and Cleveland Regional Hospital as discontinued operations in the accompanying consolidated statements of income for the years ended December 31, 2013, 2012 and 2011. As of December 31, 2013, no hospitals are held for sale.

Net operating revenues and loss from discontinued operations for the respective periods are as follows (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Net operating revenues	$ -	$ -	$ 144,546
Loss from operations of entities sold before income taxes	-	(729)	(12,390)
Impairment of hospitals sold	-	-	(51,695)
Loss on sale, net	-	-	(4,301)
Loss from discontinued operations, before taxes	-	(729)	(68,386)
Income tax benefit	-	(263)	(10,115)
Loss from discontinued operations, net of taxes	$ -	$ (466)	$ (58,271)

Interest expense was allocated to discontinued operations based on sale proceeds available for debt repayment.

4. GOODWILL AND OTHER INTANGIBLE ASSETS

The changes in the carrying amount of goodwill are as follows (in thousands):

	Year Ended December 31,	
	2013	2012
Balance, beginning of year	$ 4,408,138	$ 4,264,845
Goodwill acquired as part of acquisitions during current year	36,245	141,277
Consideration and purchase price allocation adjustments for prior year's acquisitions and other adjustments	(248)	2,016
Balance, end of year	$ 4,444,135	$ 4,408,138

Goodwill is allocated to each identified reporting unit, which is defined as an operating segment or one level below the operating segment (referred to as a component of the entity). Management has determined that the Company's operating segments and hospital management services operations meet the criteria to be classified as reporting units. At December 31, 2013, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.4 billion, $43.6 million and $33.3 million, respectively, of goodwill. At December 31, 2012, the hospital operations reporting unit, the home care agency operations reporting unit, and the hospital management services reporting unit had approximately $4.3 billion, $40.5 million and $33.3 million, respectively, of goodwill.

Goodwill is evaluated for impairment at the same time every year and when an event occurs or circumstances change that, more likely than not, reduce the fair value of the reporting unit below its carrying value. There is a two-step method for determining goodwill impairment. Step one is to compare the fair value of the reporting unit with the unit's carrying amount, including goodwill. If this test indicates the fair value is less than the carrying value, then step two is required to compare the implied fair value of the reporting unit's goodwill with the carrying value of the reporting unit's goodwill. The Company performed its last annual goodwill evaluation during the fourth quarter of 2013. No impairment was indicated by this evaluation. The next annual goodwill evaluation will be performed during the fourth quarter of 2014.

The Company estimates the fair value of the related reporting units using both a discounted cash flow model as well as an EBITDA multiple model. The cash flow forecasts are adjusted by an appropriate discount rate based on the Company's estimate of a market participant's weighted-average cost of capital. These models are both based on the Company's best estimate of future revenues and operating costs and are reconciled to the Parent's consolidated market capitalization, with consideration of the amount a potential acquirer would be required to pay, in the form of a control premium, in order to gain sufficient ownership to set policies, direct operations and control management decisions.

Approximately $1.2 million of intangible assets other than goodwill were acquired during the year ended December 31, 2013. The gross carrying amount of the Company's other intangible assets subject to amortization was $50.9 million at December 31, 2013 and $61.9 million at December 31, 2012, and the net carrying amount was $20.5 million at December 31, 2013 and $26.3 million at December 31, 2012. The carrying amount of the Company's other intangible assets not subject to amortization was $49.6 million and $48.1 million at December 31, 2013 and 2012, respectively. Other intangible assets are included in other assets, net on the Company's consolidated balance sheets. Substantially all of the Company's intangible assets are contract-based intangible assets related to operating licenses, management contracts, or non-compete agreements entered into in connection with prior acquisitions.

The weighted-average amortization period for the intangible assets subject to amortization is approximately eight years. There are no expected residual values related to these intangible assets. Amortization expense on these intangible assets was $5.6 million, $7.5 million and $8.1 million during the years ended December 31, 2013, 2012, and 2011, respectively. Amortization expense on intangible assets is estimated to be $3.8 million in 2014, $3.3 million in 2015, $2.5 million in 2016, $2.2 million in 2017, $2.0 million in 2018 and $6.7 million thereafter.

The gross carrying amount of capitalized software for internal use was approximately $987.5 million and $654.4 million at December 31, 2013 and 2012, respectively, and the net carrying amount considering accumulated amortization was approximately $559.5 million and $354.4 million at December 31, 2013 and 2012, respectively. The estimated amortization period for capitalized internal-use software is generally three years, except for capitalized costs related to significant system conversions, which is generally eight to ten years. There is no expected residual value for capitalized internal-use software. At December 31, 2013, there was approximately $141.8 million of capitalized costs for internal-use software that is currently in the development stage and will begin amortization once the software project is complete and ready for its intended use. Amortization expense on capitalized internal-use software was $140.6 million, $100.7 million and $70.5 million during the years ended December 31, 2013, 2012 and 2011, respectively. Amortization expense on capitalized internal-use software is estimated to be $143.5 million in 2014, $122.0 million in 2015, $94.2 million in 2016, $44.9 million in 2017, $38.1 million in 2018 and $116.8 million thereafter.

5. INCOME TAXES

The Parent is the tax paying entity. However, as the Parent has no operations, the provision for income taxes and all tax related accounts have been pushed down to the Company.

The provision for income taxes for income from continuing operations consists of the following (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Current:			
Federal	$ 14,674	$ 94,080	$ 23,020
State	4,636	10,015	7,601
	19,310	104,095	30,621
Deferred:			
Federal	58,331	56,487	105,771
State	10,953	(3,080)	1,261
	69,284	53,407	107,032
Total provision for income taxes for income from continuing operations	$ 88,594	$ 157,502	$ 137,653

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The following table reconciles the differences between the statutory federal income tax rate and the effective tax rate (dollars in thousands):

	Year Ended December 31,					
	2013		2012		2011	
	Amount	%	Amount	%	Amount	%
Provision for income taxes at statutory federal rate	$ 107,052	35.0 %	$ 176,320	35.0 %	$ 165,741	35.0 %
State income taxes, net of federal income tax benefit	9,560	3.1	12,293	2.4	8,212	1.7
Release of unrecognized tax benefit	-	-	-	-	(6,509)	(1.3)
Net income attributable to noncontrolling interests	(26,623)	(8.7)	(28,057)	(5.6)	(26,486)	(5.6)
Change in valuation allowance	-	-	(1,233)	(0.2)	-	-
Federal and state tax credits	(3,972)	(1.3)	(2,185)	(0.4)	(3,788)	(0.8)
Other	2,577	0.9	364	0.1	483	0.1
Provision for income taxes and effective tax rate for income from continuing operations	$ 88,594	29.0 %	$ 157,502	31.3 %	$ 137,653	29.1 %

Deferred income taxes are based on the estimated future tax effects of differences between the financial statement and tax bases of assets and liabilities under the provisions of the enacted tax laws. Deferred income taxes as of December 31, 2013 and 2012 consist of (in thousands):

	December 31,			
	2013		2012	
	Assets	Liabilities	Assets	Liabilities
Net operating loss and credit carryforwards	$ 186,519	$ -	$ 170,521	$ -
Property and equipment	-	820,035	-	762,387
Self-insurance liabilities	125,367	-	124,842	-
Intangibles	-	244,019	-	222,392
Investments in unconsolidated affiliates	-	60,257	-	64,170
Other liabilities	-	23,767	-	22,468
Long-term debt and interest	-	21,256	-	28,920
Accounts receivable	-	86,044	-	38,503
Accrued expenses	53,011	-	55,203	-
Other comprehensive income	47,265	-	102,242	-
Stock-based compensation	22,813	-	31,504	-
Deferred compensation	73,042	-	58,509	-
Other	110,813	-	65,887	-
	618,830	1,255,378	608,708	1,138,840
Valuation allowance	(171,364)	-	(161,312)	-
Total deferred income taxes	$ 447,466	$ 1,255,378	$ 447,396	$ 1,138,840

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The Company believes that the net deferred tax assets will ultimately be realized, except as noted below. Its conclusion is based on its estimate of future taxable income and the expected timing of temporary difference reversals. The Company has state net operating loss carry forwards of approximately $5.5 billion, which expire from 2014 to 2033. The Company also has unrecognized deferred tax assets primarily related to interest expense that are included in other comprehensive income. If recognized, additional state net operating losses will be created which the Company does not expect to be able to utilize prior to the expiration of the carryforward period. A valuation allowance of approximately $9.0 million has been recognized for those items. With respect to the deferred tax liability pertaining to intangibles, as included above, goodwill purchased in connection with certain of the Company's business acquisitions is amortizable for income tax reporting purposes. However, for financial reporting purposes, there is no corresponding amortization allowed with respect to such purchased goodwill.

The valuation allowance increased by $10.1 million during the year ended December 31, 2013 and increased by $11.1 million during the year ended December 31, 2012. In addition to amounts previously discussed, the change in valuation allowance relates to a redetermination of the amount of, and realizability of, net operating losses and credits in certain income tax jurisdictions.

The total amount of unrecognized benefit that would affect the effective tax rate, if recognized, was approximately $0.7 million as of December 31, 2013. A total of approximately $0.4 million of interest and penalties is included in the amount of the liability for uncertain tax positions at December 31, 2013. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its consolidated statements of income as income tax expense. During the year ended December 31, 2013, the Company decreased liabilities for uncertain tax positions by $0.2 million. It is the Company's policy to recognize interest and penalties related to unrecognized benefits in its consolidated statements of income as income tax expense.

It is possible the amount of unrecognized tax benefit could change in the next twelve months as a result of a lapse of the statute of limitations and settlements with taxing authorities; however, the Company does not anticipate the change will have a material impact on its consolidated financial statements.

The following is a tabular reconciliation of the total amount of unrecognized tax benefit for the years ended December 31, 2013, 2012 and 2011 (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Unrecognized tax benefit, beginning of year	$ 682	$ 629	$ 7,458
Gross increases — tax positions in prior period	195	1,515	349
Reductions — tax positions in prior period	-	-	(3,469)
Lapse of statute of limitations	-	-	(3,575)
Settlements	(402)	(1,462)	(134)
Unrecognized tax benefit, end of year	$ 475	$ 682	$ 629

The Parent, or one of its subsidiaries, files income tax returns in the United States federal jurisdiction and various state jurisdictions. The Parent has extended the federal statute of limitations through December 31, 2014 for Triad Hospitals, Inc. ("Triad") for the tax periods ended December 31, 1999, December 31, 2000, April 30, 2001, June 30, 2001, December 31, 2001, December 31, 2002, December 31, 2003, December 31, 2004, December 31, 2005, December 31, 2006 and July 25, 2007. With few exceptions, the Parent is no longer subject to state income tax examinations for years prior to 2010. The Parent's federal income tax returns for the 2009 and 2010 tax years are currently under examination by the Internal Revenue Service ("IRS"). The Parent believes the results of these examinations will not be material to its consolidated results of operations or consolidated financial position. During the year ended December 31, 2013, the IRS concluded its examination of the federal tax return of Community Health Systems, Inc. for the tax periods ended December 31, 2007 and 2008. The results of these examinations did not have a material effect on the Parent's consolidated results of operations or consolidated financial position. The Parent has extended the federal statute of limitations through December 31, 2014 for Community Health Systems, Inc. for the tax periods ended December 31, 2007 and 2008, and through July 18, 2014 for the tax period ended December 31, 2009.

Cash paid for income taxes, net of refunds received, resulted in net cash paid of $72.8 million, $55.6 million and $26.5 million during the years ended December 31, 2013, 2012 and 2011, respectively.

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6. LONG-TERM DEBT

Long-term debt consists of the following (in thousands):

	December 31, 2013	December 31, 2012
Credit Facility:		
Term loan A	$ 637,500	$ 712,500
Term loan B	3,412,584	3,619,062
Revolving credit loans	-	-
8% Senior Notes due 2019	2,020,346	2,022,829
7⅛% Senior Notes due 2020	1,200,000	1,200,000
5⅛% Senior Secured Notes due 2018	1,600,000	1,600,000
Receivables Facility	500,000	300,000
Capital lease obligations	46,066	47,951
Other	36,901	38,963
Total debt	9,453,397	9,541,305
Less current maturities	(166,902)	(89,911)
Total long-term debt	$ 9,286,495	$ 9,451,394

Credit Facility

The Company obtained senior secured financing under a credit facility (the "Credit Facility") with a syndicate of financial institutions led by Credit Suisse, as administrative agent and collateral agent. The Credit Facility includes a $750 million revolving credit facility for working capital and general corporate purposes. The revolving credit facility also includes a subfacility for letters of credit and a swingline subfacility. The Credit Facility requires quarterly amortization payments of each term loan B facility equal to 0.25% of the outstanding amount of such term loans. On November 5, 2010, the Company entered into an amendment and restatement of the Credit Facility. The amendment extended by two and a half years, until January 25, 2017, the maturity date of $1.5 billion of the existing term loans under the Credit Facility and increased the pricing on these term loans to LIBOR plus 350 basis points. The amendment also increased the Company' ability to issue additional indebtedness under the uncommitted incremental facility to $1.0 billion from $600 million, permitted the Company to issue term loan A loans under the incremental facility, and provided up to $2.0 billion of borrowing capacity from receivable transactions, an increase of $0.5 billion, of which approximately $1.7 billion would be required to be used for repayment of existing term loans. On February 2, 2012, the Company completed a second amendment and restatement of the Credit Facility to extend an additional $1.6 billion of the term loans due 2014 under the Credit Facility to match the maturity date and interest rate margins of the term loans due January 25, 2017.

On August 3, 2012, the Company entered into Amendment No. 1 to the Credit Facility to provide increased flexibility for refinancing and repayment of the term loans due 2014 and amend certain other terms. On August 17, 2012, the Company made a prepayment of $1.6 billion on the term loans due July 25, 2014, utilizing the proceeds from the issuance of $1.6 billion of 5⅛% Senior Secured Notes due 2018. On August 22, 2012, the Company entered into a loan modification agreement with respect to the Credit Facility to extend approximately $340 million of the term loans due 2014 to match the maturity date and interest rate margins of the term loans due January 25, 2017.

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On November 27, 2012, the Company entered into Amendment No. 2 to the Credit Facility to provide increased flexibility for the Company to make investments and restricted payments, incur debt related to acquisitions, amend certain other terms of the Credit Facility, including the maximum leverage ratio and interest coverage ratio financial coverage levels, and add a one year 1% prepayment premium payable in connection with a repricing of the term loans due in 2017. During the year ended December 31, 2013, the Company paid down $206.5 million of the term loans due 2014. The remaining balance of the non-extended term loans due 2014 at December 31, 2013 of approximately $59.6 million was paid as part of the financing for the HMA merger on January 27, 2014.

On August 12, 2013, the Company entered into Amendment No. 3 to the Credit Facility to provide increased flexibility for the Company to incur debt by amending certain terms of the Credit Facility, including the maximum leverage ratio and secured leverage ratio covenant levels. In addition, the amendment includes pricing protection for certain term loans due January 25, 2017, which specifies an increased margin in certain instances. The amendment also provides for a total leverage-based step-up to the applicable margin of the term loans due January 25, 2017 and the term loans due July 25, 2014. The pricing of the loans under the Credit Facility will otherwise remain unchanged.

Effective March 6, 2012, the Company obtained a new $750 million senior secured revolving credit facility (the "Replacement Revolver Facility") and a new $750 million incremental term loan A facility (the "Incremental Term Loan") subject to the terms and conditions set forth in the Credit Facility. The Replacement Revolver Facility replaced in full the existing revolving credit facility under the Credit Facility. The net proceeds of the Incremental Term Loan were used to repay the same amount of the existing term loans under the Credit Facility. Both the Replacement Revolver Facility and the Incremental Term Loan have a maturity date of October 25, 2016, subject to customary acceleration events and to earlier maturity if the repayment, extension or refinancing with longer maturity debt of substantially all of the Company's then outstanding term loans maturing July 25, 2014 and the now fully redeemed 8⅞% Senior Notes does not occur by April 25, 2014. The pricing on each of the Replacement Revolver Facility and the Incremental Term Loan is initially LIBOR plus a margin of 250 basis points, subject to adjustment based on the Company's leverage ratio. The Incremental Term Loan amortizes at 5% in year one, 10% in years two and three, 15% in year four and 60% in year five.

The term loan facility must be prepaid in an amount equal to (1) 100% of the net cash proceeds of certain asset sales and dispositions by the Company and its subsidiaries, subject to certain exceptions and reinvestment rights, (2) 100% of the net cash proceeds of issuances of certain debt obligations or receivables-based financing by the Company and its subsidiaries, subject to certain exceptions, and (3) 50%, subject to reduction to a lower percentage based on the Company's leverage ratio (as defined in the Credit Facility generally as the ratio of total debt on the date of determination to the Company's EBITDA, as defined, for the four quarters most recently ended prior to such date), of excess cash flow (as defined) for any year, commencing in 2008, subject to certain exceptions. Voluntary prepayments and commitment reductions are permitted in whole or in part, without any premium or penalty, subject to minimum prepayment or reduction requirements.

The obligor under the Credit Facility is the Company. All of the obligations under the Credit Facility are unconditionally guaranteed by the Parent and certain of its existing and subsequently acquired or organized domestic subsidiaries. All obligations under the Credit Facility and the related guarantees are secured by a perfected first priority lien or security interest in substantially all of the assets of the Parent , the Company and each subsidiary guarantor, including equity interests held by the Parent, the Company or any subsidiary guarantor, but excluding, among others, the equity interests of non-significant subsidiaries, syndication subsidiaries, securitization subsidiaries and joint venture subsidiaries.

The loans under the Credit Facility bear interest on the outstanding unpaid principal amount at a rate equal to an applicable percentage plus, at the Company's option, either (a) an Alternate Base Rate (as defined) determined by reference to the greater of (1) the Prime Rate (as defined) announced by Credit Suisse or (2) the Federal Funds Effective Rate (as defined) plus 0.50% or (3) the adjusted London Interbank Offered Rate ("LIBOR") on such day for a three-month interest period commencing on the second business day after such day plus 1%, or (b) a reserve adjusted LIBOR for dollars (Eurodollar rate) (as defined). The applicable percentage for Alternate Base Rate loans is 1.25% for term loans due 2014 and is 2.50% for term loans due 2017. The applicable percentage for Eurodollar rate loans is 2.25% for term loans due 2014 and 3.50% for term loans due 2017. The applicable percentage for revolving loans and the Incremental Term Loan is 1.50% for Alternate Base Rate loans and 2.50% for Eurodollar loans. The applicable percentage for the loans under the Credit Facility is subject to adjustment based on the Company's leverage ratio. Loans under the swingline subfacility bear interest at the rate applicable to Alternate Base Rate loans under the Credit Facility.

The Company has agreed to pay letter of credit fees equal to the applicable percentage then in effect with respect to Eurodollar rate loans under the revolving credit facility times the maximum aggregate amount available to be drawn under all letters of credit outstanding under the subfacility for letters of credit. The issuer of any letter of credit issued under the subfacility for letters of credit will also receive a customary fronting fee and other customary processing charges. The Company is obligated to pay commitment fees of 0.50% per annum (subject to reduction based upon the Company's leverage ratio) on the unused portion of the revolving credit facility. For purposes of this calculation, swingline loans are not treated as usage of the revolving credit facility.

The Credit Facility contains customary representations and warranties, subject to limitations and exceptions, and customary covenants restricting the Company's and its subsidiaries' ability, subject to certain exceptions, to, among other things (1) declare dividends, make distributions or redeem or repurchase capital stock, (2) prepay, redeem or repurchase other debt, (3) incur liens or grant negative pledges, (4) make loans and investments and enter into acquisitions and joint ventures, (5) incur additional indebtedness or provide certain guarantees, (6) make capital expenditures, (7) engage in mergers, acquisitions and asset sales, (8) conduct transactions with affiliates, (9) alter the nature of the Company's businesses, (10) grant certain guarantees with respect to physician practices, (11) engage in sale and leaseback transactions or (12) change the Company's fiscal year. The Company is also required to comply with specified financial covenants (consisting of a leverage ratio and an interest coverage ratio) and various affirmative covenants.

Events of default under the Credit Facility include, but are not limited to, (1) the Company's failure to pay principal, interest, fees or other amounts under the credit agreement when due (taking into account any applicable grace period), (2) any representation or warranty proving to have been materially incorrect when made, (3) covenant defaults subject, with respect to certain covenants, to a grace period, (4) bankruptcy events, (5) a cross default to certain other debt, (6) certain undischarged judgments (not paid within an applicable grace period), (7) a change of control, (8) certain ERISA-related defaults and (9) the invalidity or impairment of specified security interests, guarantees or subordination provisions in favor of the administrative agent or lenders under the Credit Facility.

As of December 31, 2013, the availability for additional borrowings under the Credit Facility was approximately $750.0 million pursuant to the Replacement Revolver Facility, of which $19.4 million was set aside for outstanding letters of credit. The Company has the ability to amend the Credit Facility to provide for one or more tranches of term loans in an aggregate principal amount of $1.0 billion, which the Company has not yet accessed. As of December 31, 2013, the weighted-average interest rate under the Credit Facility, excluding swaps, was 3.9%.

As of December 31, 2013, the term loans are scheduled to be paid with principal payments for future years as follows (in thousands):

Year	Amount
2014	$ 152,050
2015	147,336
2016	484,836
2017	3,265,862
2018	-
Thereafter	-
Total	$ 4,050,084

See Note 15 for a description and revised maturities of the term loans under the amended and restated Credit Facility in conjunction with the HMA merger.

As of December 31, 2013 and 2012, the Company had letters of credit issued, primarily in support of potential insurance-related claims and certain bonds, of approximately $19.4 million and $37.8 million, respectively.

8⅞% Senior Notes due 2015

On July 25, 2007, the Company completed its offering of approximately $3.0 billion aggregate principal amount of 8⅞% Senior Notes due 2015 (the "8⅞% Senior Notes"), which were issued in a private placement. The 8⅞% Senior Notes were to mature on July 15, 2015. The 8⅞% Senior Notes bore interest at the rate of 8.875% per annum, payable semiannually in arrears on January 15 and July 15, commencing January 15, 2008. Interest on the 8⅞% Senior Notes accrued from the date of original issuance. Interest was calculated on the basis of a 360-day year comprised of twelve 30-day months.

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Pursuant to a registration rights agreement entered into at the time of the issuance of the 8⅛% Senior Notes, as a result of an exchange offer made by the Company, substantially all of the 8⅛% Senior Notes issued in July 2007 were exchanged in November 2007 for new notes (the "8⅛% Exchange Notes") having terms substantially identical in all material respects to the 8⅛% Senior Notes (except that the 8⅛% Exchange Notes were issued under a registration statement pursuant to the 1933 Act). References to the 8⅛% Senior Notes shall also be deemed to include the 8⅛% Exchange Notes unless the context provides otherwise.

On March 21, 2012, the Company completed the cash tender offer for $850 million of the then $1.8 billion aggregate outstanding principal amount of the 8⅛% Senior Notes.

On July 18, 2012, the Company completed the cash tender offer for $639.7 million of the then $934.3 million aggregate outstanding principal amount of the 8⅛% Senior Notes. On August 17, 2012, pursuant to its redemption option, the Company redeemed the remaining $294.6 million outstanding principal of the 8⅛% Senior Notes.

8% Senior Notes due 2019

On November 22, 2011, the Company completed its offering of $1.0 billion aggregate principal amount of 8% Senior Notes due 2019 (the "8% Senior Notes"), which were issued in a private placement. The net proceeds from this issuance, together with available cash on hand, were used to finance the purchase of up to $1.0 billion aggregate principal amount of the Company's then outstanding 8⅛% Senior Notes and related fees and expenses. On March 21, 2012, the Company completed the secondary offering of $1.0 billion aggregate principal amount of 8% Senior Notes, which were issued in a private placement (at a premium of 102.5%). The net proceeds from this issuance were used to finance the purchase of approximately $850 million aggregate principal amount of the Company's then outstanding 8⅛% Senior Notes, to pay related fees and expenses and for general corporate purposes. The 8% Senior Notes bear interest at 8% per annum, payable semiannually in arrears on May 15 and November 15, commencing May 15, 2012. Interest on the 8% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

Except as set forth below, the Company is not entitled to redeem the 8% Senior Notes prior to November 15, 2015.

Prior to November 15, 2014, the Company is entitled, at its option, to redeem a portion of the 8% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price equal to 108% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to November 15, 2015, the Company may redeem some or all of the 8% Senior Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the 8% Senior Notes indenture. On and after November 15, 2015, the Company is entitled, at its option, to redeem all or a portion of the 8% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
November 15, 2015 to November 14, 2016	104.000 %
November 15, 2016 to November 14, 2017	102.000 %
November 15, 2017 to November 15, 2019	100.000 %

Pursuant to a registration rights agreement entered into at the time of the issuance of the 8% Senior Notes, as a result of an exchange offer made by the Company, substantially all of the 8% Senior Notes issued in November 2011 and March 2012 were exchanged in May 2012 for new notes (the "8% Exchange Notes") having terms substantially identical in all material respects to the 8% Senior Notes (except that the 8% Exchange Notes were issued under a registration statement pursuant to the 1933 Act). References to the 8% Senior Notes shall also be deemed to include the 8% Exchange Notes unless the context provides otherwise.

7⅛% Senior Notes due 2020

On July 18, 2012, the Company completed an underwritten public offering under its automatic shelf registration filed with the SEC of $1.2 billion aggregate principal amount of 7⅛% Senior Notes due 2020 (the "7⅛% Senior Notes"). The net proceeds from this issuance were used to finance the purchase or redemption of $934.3 million aggregate principal amount plus accrued interest of the Company's outstanding 8⅞% Senior Notes, to pay for consents delivered in connection therewith, to pay related fees and expenses, and for general corporate purposes. The 7⅛% Senior Notes bear interest at 7.125% per annum, payable semiannually in arrears on July 15 and January 15, commencing January 15, 2013. Interest on the 7⅛% Senior Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months.

Except as set forth below, the Company is not entitled to redeem the 7⅛% Senior Notes prior to July 15, 2016.

Prior to July 15, 2015, the Company is entitled, at its option, to redeem a portion of the 7⅛% Senior Notes (not to exceed 35% of the outstanding principal amount) at a redemption price equal to 107.125% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to July 15, 2016, the Company may redeem some or all of the 7⅛% Senior Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the 7⅛% Senior Notes indenture. On and after July 15, 2016, the Company is entitled, at its option, to redeem all or a portion of the 7⅛% Senior Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
July 15, 2016 to July 14, 2017	103.563 %
July 15, 2017 to July 14, 2018	101.781 %
July 15, 2018 to July 15, 2020	100.000 %

5⅛% Senior Secured Notes due 2018

On August 17, 2012, the Company completed an underwritten public offering under its automatic shelf registration filed with the SEC of $1.6 billion aggregate principal amount of 5⅛% Senior Secured Notes due 2018 (the "5⅛% Senior Secured Notes"). The net proceeds from this issuance, together with available cash on hand, were used to finance the prepayment of $1.6 billion of the outstanding term loans due 2014 under the Credit Facility and related fees and expenses. The 5⅛% Senior Secured Notes bear interest at 5.125% per annum, payable semiannually in arrears on August 15 and February 15, commencing February 15, 2013. Interest on the 5⅛% Senior Secured Notes accrues from the date of original issuance. Interest is calculated on the basis of a 360-day year comprised of twelve 30-day months. The 5⅛% Senior Secured Notes are secured by a first-priority lien subject to a shared lien of equal priority with certain other obligations, including obligations under the Credit Facility, and subject to prior ranking liens permitted by the indenture governing the 5⅛% Senior Secured Notes on substantially the same assets, subject to certain exceptions, that secure the Company's obligations under the Credit Facility.

Except as set forth below, the Company is not entitled to redeem the 5⅛% Senior Secured Notes prior to August 15, 2015.

Prior to August 15, 2015, the Company is entitled, at its option, to redeem a portion of the 5⅛% Senior Secured Notes (not to exceed 35% of the outstanding principal amount) at a redemption price equal to 105.125% of the principal amount of the notes redeemed plus accrued and unpaid interest, with the proceeds from certain public equity offerings. Prior to August 15, 2015, the Company may redeem some or all of the 5⅛% Senior Secured Notes at a redemption price equal to 100% of the principal amount of the notes redeemed plus accrued and unpaid interest, if any, plus a "make-whole" premium, as described in the 5⅛% Senior Secured Notes indenture. On and after August 15, 2015, the Company is entitled, at its option, to redeem all or a portion of the 5⅛% Senior Secured Notes upon not less than 30 nor more than 60 days' notice, at the following redemption prices (expressed as a percentage of principal amount on the redemption date), plus accrued and unpaid interest, if any, to the redemption date (subject to the right of holders of record on the relevant record date to receive interest due on the relevant interest payment date), if redeemed during the periods set forth below:

Period	Redemption Price
August 15, 2015 to August 14, 2016	102.563 %
August 15, 2016 to August 14, 2017	101.281 %
August 15, 2017 to August 15, 2018	100.000 %

Receivables Facility

On March 21, 2012, the Company and certain of its subsidiaries entered into an accounts receivable loan agreement (the "Receivables Facility") with a group of lenders and banks, Credit Agricolé Corporate and Investment Bank, as a managing agent and as the administrative agent, and The Bank of Nova Scotia, as a managing agent. On March 7, 2013, the Company and certain of its subsidiaries amended the Receivables Facility to add an additional managing agent, The Bank of Tokyo-Mitsubishi UFJ, Ltd., to increase the size of the facility from $300 million to $500 million and to extend the scheduled termination date. Additional subsidiaries of the Company also agreed to participate in the Receivables Facility as of that date. The existing and future non-self pay patient-related accounts receivable (the "Receivables") for certain of the Company's hospitals serves as collateral for the outstanding borrowings under the Receivables Facility. The interest rate on the borrowings is based on the commercial paper rate plus an applicable interest rate spread. Unless earlier terminated or subsequently extended pursuant to its terms, the Receivables Facility will expire on March 21, 2015, subject to customary termination events that could cause an early termination date. The Company maintains effective control over the Receivables because, pursuant to the terms of the Receivables Facility, the Receivables are sold from certain of the Company's subsidiaries to the Company, which then sells or contributes the Receivables to a special-purpose entity that is wholly-owned by the Company. The wholly-owned special-purpose entity in turn grants security interests in the Receivables in exchange for borrowings obtained from the group of third-party lenders and banks of up to $500 million outstanding from time to time based on the availability of eligible Receivables and other customary factors. The group of third-party lenders and banks do not have recourse to the Company or its subsidiaries beyond the assets of the wholly-owned special-purpose entity that collateralizes the loan. The Receivables and other assets of the wholly-owned special-purpose entity will be available first and foremost to satisfy the claims of the creditors of such entity. The outstanding borrowings pursuant to the Receivables Facility at December 31, 2013 totaled $500.0 million and are classified as long-term debt on the consolidated balance sheet. At December 31, 2013, the carrying amount of Receivables included in the Receivables Facility totaled approximately $1.0 billion and is included in patient accounts receivable on the consolidated balance sheet.

Loss from Early Extinguishment of Debt

The financing transactions discussed above resulted in a loss from early extinguishment of debt of $1.3 million, $115.5 million and $66.0 million for the years ended December 31, 2013, 2012 and 2011, respectively, and an after-tax loss of $0.8 million, $71.8 million and $42.0 million for years ended December 31, 2013, 2012 and 2011, respectively.

Other Debt

As of December 31, 2013, other debt consisted primarily of the mortgage obligation on the Company's corporate headquarters and other obligations maturing in various installments through 2020.

To limit the effect of changes in interest rates on a portion of the Company's long-term borrowings, the Company is a party to 14 separate interest swap agreements in effect at December 31, 2013, with an aggregate notional amount of $2.0 billion, and two forward-starting swap agreements with an aggregate notional amount of $400 million. On each of these swaps, the Company receives a variable rate of interest based on the three-month LIBOR in exchange for the payment of a fixed rate of interest. The Company currently pays, on a quarterly basis, a margin above LIBOR of 225 basis points for the outstanding balance of term loans due in 2014, 250 basis points for the Replacement Revolver Facility and the Incremental Term Loan and 350 basis points for term loans due in 2017 under the Credit Facility. See Note 7 for additional information regarding these swaps.

As of December 31, 2013, the scheduled maturities of long-term debt outstanding, including capital lease obligations for each of the next five years and thereafter are as follows (in thousands):

Year		Amount
2014	$	166,902
2015		654,874
2016		488,902
2017		3,287,695
2018		1,603,565
Thereafter		3,231,113
Total maturities		9,433,051
Plus unamortized note premium		20,346
Total long-term debt	$	9,453,397

The Company paid interest of $582.8 million, $594.3 million and $680.7 million on borrowings during the years ended December 31, 2013, 2012 and 2011, respectively.

7. FAIR VALUE OF FINANCIAL INSTRUMENTS

The fair value of financial instruments has been estimated by the Company using available market information as of December 31, 2013 and 2012, and valuation methodologies considered appropriate. The estimates presented are not necessarily indicative of amounts the Company could realize in a current market exchange (in thousands):

	December 31,			
	2013		2012	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Assets:				
Cash and cash equivalents	$ 373,403	$ 373,403	$ 387,813	$ 387,813
Available-for-sale securities	64,869	64,869	56,376	56,376
Trading securities	37,999	37,999	34,696	34,696
Liabilities:				
Credit Facility	4,050,084	4,084,983	4,331,562	4,357,910
8% Senior Notes	2,020,346	2,172,440	2,022,829	2,185,220
7⅛% Senior Notes	1,200,000	1,245,720	1,200,000	1,285,848
5⅛% Senior Secured Notes	1,600,000	1,662,160	1,600,000	1,674,480
Receivables Facility and other debt	536,901	536,901	338,963	338,963

The estimated fair value is determined using the methodologies discussed below in accordance with accounting standards related to the determination of fair value based on the U.S. GAAP fair value hierarchy as discussed in Note 8. The estimated fair value for financial instruments with a fair value that does not equal its carrying value is considered a Level 1 valuation. The Company utilizes the market approach and obtains indicative pricing from the administrative agent to the Credit Facility to determine fair values, which are validated through publicly available subscription services such as Bloomberg where relevant.

Cash and cash equivalents. The carrying amount approximates fair value due to the short-term maturity of these instruments (less than three months).

Available-for-sale securities. Estimated fair value is based on closing price as quoted in public markets.

Trading securities. Estimated fair value is based on closing price as quoted in public markets.

Credit Facility. Estimated fair value is based on information from the Company's bankers regarding relevant pricing for trading activity among the Company's lending institutions.

8% Senior Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as underwriters in the sale of these notes.

7⅛% Senior Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as underwriters in the sale of these notes.

5⅛% Senior Secured Notes. Estimated fair value is based on the average bid and ask price as quoted by the bank who served as underwriters in the sale of these notes.

Receivables Facility and other debt. The carrying amount of the Receivables Facility and all other debt approximates fair value due to the nature of these obligations.

Interest rate swaps. The fair value of interest rate swap agreements is the amount at which they could be settled, based on estimates calculated by the Company using a discounted cash flow analysis based on observable market inputs and validated by comparison to estimates obtained from the counterparty. The Company incorporates credit valuation adjustments ("CVAs") to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements.

The Company assesses the effectiveness of its hedge instruments on a quarterly basis. For the years ended December 31, 2013 and 2012, the Company completed an assessment of the cash flow hedge instruments and determined the hedges to be highly effective. The Company has also determined that the ineffective portion of the hedges do not have a material effect on the Company's consolidated financial position, operations or cash flows. The counterparties to the interest rate swap agreements expose the Company to credit risk in the event of nonperformance. However, at December 31, 2013, since the majority of the swap agreements entered into by the Company were in a net liability position so that the Company would be required to make the net settlement payments to the counterparties; the Company does not anticipate nonperformance by those counterparties. The Company does not hold or issue derivative financial instruments for trading purposes.

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Interest rate swaps consisted of the following at December 31, 2013:

Swap #	Notional Amount (in thousands)	Fixed Interest Rate	Termination Date	Fair Value (in thousands)
1	$ 100,000	5.231 %	July 25, 2014	$ 2,818
2	100,000	5.231 %	July 25, 2014	2,818
3	200,000	5.160 %	July 25, 2014	5,556
4	75,000	5.041 %	July 25, 2014	2,033
5	125,000	5.022 %	July 25, 2014	3,374
6	100,000	2.621 %	July 25. 2014	1,336
7	100,000	3.110 %	July 25, 2014	1,613
8	100,000	3.258 %	July 25, 2014	1,697
9	200,000	2.693 %	October 26, 2014	3,977
10	300,000	3.447 %	August 8, 2016	21,597
11	200,000	3.429 %	August 19, 2016	14,403
12	100,000	3.401 %	August 19, 2016	7,130
13	200,000	3.500 %	August 30, 2016	14,884
14	100,000	3.005 %	November 30, 2016	6,376
15	200,000	2.055 %	July 25, 2019	(954)[1]
16	200,000	2.059 %	July 25, 2019	(895)[2]

(1) This interest rate swap becomes effective July 25, 2014.
(2) This interest rate swap becomes effective July 25, 2014.

The Company is exposed to certain risks relating to its ongoing business operations. The risk managed by using derivative instruments is interest rate risk. Interest rate swaps are entered into to manage interest rate fluctuation risk associated with the term loans in the Credit Facility. Companies are required to recognize all derivative instruments as either assets or liabilities at fair value in the consolidated statement of financial position. The Company designates its interest rate swaps as cash flow hedges. For derivative instruments that are designated and qualify as cash flow hedges, the effective portion of the gain or loss on the derivative is reported as a component of OCI and reclassified into earnings in the same period or periods during which the hedged transactions affect earnings. Gains and losses on the derivative representing either hedge ineffectiveness or hedge components excluded from the assessment of effectiveness are recognized in current earnings.

Assuming no change in December 31, 2013 interest rates, approximately $57.1 million of interest expense resulting from the spread between the fixed and floating rates defined in each interest rate swap agreement will be recognized during the next 12 months. If interest rate swaps do not remain highly effective as a cash flow hedge, the derivatives' gains or losses resulting from the change in fair value reported through OCI will be reclassified into earnings.

The following tabular disclosure provides the amount of pre-tax loss recognized as a component of OCI during the years ended December 31, 2013 and 2012 (in thousands):

Derivatives in Cash Flow Hedging Relationships	Amount of Pre-Tax Loss Recognized in OCI (Effective Portion) Year Ended December 31, 2013	2012
Interest rate swaps	$ (5,970)	$ (69,020)

The following tabular disclosure provides the location of the effective portion of the pre-tax loss reclassified from accumulated other comprehensive loss ("AOCL") into interest expense on the consolidated statements of income during the years ended December 31, 2013 and 2012 (in thousands):

Location of Loss Reclassified from AOCL into Income (Effective Portion)	Amount of Pre-Tax Loss Reclassified from AOCL into Income (Effective Portion) Year Ended December 31, 2013	2012
Interest expense, net	$ 99,808	$ 141,648

The fair values of derivative instruments in the consolidated balance sheets as of December 31, 2013 and 2012 were as follows (in thousands):

	Asset Derivatives				Liability Derivatives			
	December 31, 2013		December 31, 2012		December 31, 2013		December 31, 2012	
	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value	Balance Sheet Location	Fair Value
Derivatives designated as hedging instruments	Other assets, net	$ -	Other assets, net	$ -	Other long-term liabilities	$ 87,763	Other long-term liabilities	$ 181,600

8. FAIR VALUE

Fair Value Hierarchy

Fair value is a market-based measurement. not an entity-specific measurement. Therefore, a fair value measurement should be determined based on the assumptions that market participants would use in pricing the asset or liability. As a basis for considering market participant assumptions in fair value measurements, the Company utilizes the U.S. GAAP fair value hierarchy that distinguishes between market participant assumptions based on market data obtained from sources independent of the reporting entity (observable inputs that are classified within Levels 1 and 2 of the hierarchy) and the reporting entity's own assumption about market participant assumptions (unobservable inputs classified within Level 3 of the hierarchy).

The inputs used to measure fair value are classified into the following fair value hierarchy:

Level 1: Quoted market prices in active markets for identical assets or liabilities.

Level 2: Observable market-based inputs or unobservable inputs that are corroborated by market data.

Level 3: Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities. Level 3 includes values determined using pricing models, discounted cash flow methodologies, or similar techniques reflecting the Company's own assumptions.

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In instances where the determination of the fair value hierarchy measurement is based on inputs from different levels of the fair value hierarchy, the level in the fair value hierarchy within which the entire fair value measurement falls is based on the lowest level input that is significant to the fair value measurement in its entirety. The Company's assessment of the significance of a particular input to the fair value measurement in its entirety requires judgment of factors specific to the asset or liability.

The following table sets forth, by level within the fair value hierarchy, the financial assets and liabilities recorded at fair value on a recurring basis as of December 31, 2013 and 2012 (in thousands):

	December 31, 2013	Level 1	Level 2	Level 3
Available-for-sale securities	$ 64,869	$ 64,869	$ -	$ -
Trading securities	37,999	37,999	-	-
Total assets	$ 102,868	$ 102,868	$ -	$ -
Fair value of interest rate swap agreements	$ 87,763	$ -	$ 87,763	$ -
Total liabilities	$ 87,763	$ -	$ 87,763	$ -

	December 31, 2012	Level 1	Level 2	Level 3
Available-for-sale securities	$ 56,376	$ 56,376	$ -	$ -
Trading securities	34,696	34,696	-	-
Total assets	$ 91,072	$ 91,072	$ -	$ -
Fair value of interest rate swap agreements	$ 181,600	$ -	$ 181,600	$ -
Total liabilities	$ 181,600	$ -	$ 181,600	$ -

Available-for-sale securities and trading securities classified as Level 1 are measured using quoted market prices.

The valuation of the Company's interest rate swap agreements is determined using market valuation techniques, including discounted cash flow analysis on the expected cash flows of each agreement. This analysis reflects the contractual terms of the agreement, including the period to maturity, and uses observable market-based inputs, including forward interest rate curves. The fair value of interest rate swap agreements are determined by netting the discounted future fixed cash payments and the discounted expected variable cash receipts. The variable cash receipts are based on the expectation of future interest rates based on observable market forward interest rate curves and the notional amount being hedged.

The Company incorporates CVAs to appropriately reflect both its own nonperformance or credit risk and the respective counterparty's nonperformance or credit risk in the fair value measurements. In adjusting the fair value of its interest rate swap agreements for the effect of nonperformance or credit risk, the Company has considered the impact of any netting features included in the agreements. The CVA on the Company's interest rate swap agreements at December 31, 2013 resulted in a decrease in the fair value of the related liability of $0.9 million and an after-tax adjustment of $0.6 million to OCI. The CVA on the Company's interest rate swap agreements at December 31, 2012 resulted in a decrease in the fair value of the related liability of $3.6 million and an after-tax adjustment of $2.3 million to OCI.

The majority of the inputs used to value its interest rate swap agreements, including the forward interest rate curves and market perceptions of the Company's credit risk used in the CVAs, are observable inputs available to a market participant. As a result, the Company has determined that the interest rate swap valuations are classified in Level 2 of the fair value hierarchy.

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9. LEASES

The Company leases hospitals, medical office buildings, and certain equipment under capital and operating lease agreements. During 2013, 2012 and 2011, the Company entered into capital lease obligations of $4.3 million, $5.0 million and $3.0 million, respectively. All lease agreements generally require the Company to pay maintenance, repairs, property taxes and insurance costs.

Commitments relating to noncancellable operating and capital leases for each of the next five years and thereafter are as follows (in thousands):

Year Ended December 31,	Operating (1)	Capital
2014	$ 192,481	$ 9,289
2015	160,638	7,428
2016	120,138	6,060
2017	89,717	5,663
2018	62,321	5,533
Thereafter	155,247	46,949
Total minimum future payments	$ 780,542	80,922
Less: Imputed interest		(34,856)
Total capital lease obligations		46,066
Less: Current portion		(5,439)
Long-term capital lease obligations		$ 40,627

(1) Minimum lease payments have not been reduced by minimum sublease rentals due in the future of $16.8 million.

Assets capitalized under capital leases as reflected in the accompanying consolidated balance sheets were $27.9 million of land and improvements, $200.1 million of buildings and improvements and $64.5 million of equipment and fixtures as of December 31, 2013 and $27.9 million of land and improvements, $200.1 million of buildings and improvements and $65.1 million of equipment and fixtures as of December 31, 2012. The accumulated depreciation related to assets under capital leases was $147.3 million and $129.1 million as of December 31, 2013 and 2012, respectively. Depreciation of assets under capital leases is included in depreciation and amortization expense and amortization of debt discounts on capital lease obligations is included in interest expense in the accompanying consolidated statements of income.

10. EMPLOYEE BENEFIT PLANS

The Company maintains various benefit plans, including defined contribution plans, defined benefit plans and deferred compensation plans, for which the Company is the plan sponsor. The CHS/Community Health Systems, Inc. Retirement Savings Plan is a defined contribution plan which covers the majority of the employees of the Company. Employees of certain subsidiaries whose employment is covered by collective bargaining agreements are eligible to participate in one of several other defined contribution plans including the CHS/Community Health Systems, Inc. Standard 401(k) Plan, which was established effective October 1, 2010 for the benefit of employees at the three hospitals acquired in Youngstown, Ohio and Warren, Ohio and their beneficiaries. This plan is structured such that employees of other subsidiaries may become eligible to participate as new entities are acquired by the Company or upon changes to collective bargaining agreements covering participants in the other defined contribution plans. Total expense to the Company under the 401(k) plans was $101.5 million, $108.5 million and $101.7 million for the years ended December 31, 2013, 2012 and 2011, respectively.

The Company maintains unfunded deferred compensation plans that allow participants to defer receipt of a portion of their compensation. The liability for the deferred compensation plans was $111.6 million and $87.3 million as of December 31, 2013 and 2012, respectively, and is included in other long-term liabilities on the consolidated balance sheets. The Company had assets of $109.1 million and $87.1 million as of December 31, 2013 and 2012, respectively, in a non-qualified plan trust generally designated to pay benefits of the deferred compensation plans, consisting of trading securities of $38.0 million and $34.7 million as of December 31, 2013 and 2012, respectively, and company-owned life insurance contracts of $71.1 million and $52.4 million as of December 31, 2013 and 2012, respectively.

The Company provides an unfunded Supplemental Executive Retirement Plan ("SERP") for certain members of its executive management. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the SERP. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations and net periodic cost in future periods. Benefits expense under the SERP was $14.2 million, $12.9 million and $11.9 million for the years ended December 31, 2013, 2012 and 2011, respectively. The accrued benefit liability for the SERP totaled $105.3 million at December 31, 2013 and $104.8 million at December 31, 2012, and is included in other long-term liabilities on the consolidated balance sheets. The weighted-average assumptions used in determining net periodic cost for the year ended December 31, 2013 was a discount rate of 3.0% and annual salary increase of 4.0%. The estimated future benefit payments reflecting future service as of December 31, 2013 are $1.5 million for 2014, $16.0 million for 2015, $43.9 million for 2016, $17.8 million for 2017, $7.2 million for 2018, and $21.2 million for the five years thereafter. The Company had available-for-sale securities in a rabbi trust generally designated to pay benefits of the SERP in the amounts of $64.9 million and $56.4 million at December 31, 2013 and 2012, respectively. These amounts are included in other assets, net on the consolidated balance sheets.

The Company maintains the CHS/Community Health Systems, Inc. Retirement Income Plan ("Pension Plan"), which is a defined benefit, non-contributory pension plan that covers certain employees at three of its hospitals. The Pension Plan provides benefits to covered individuals satisfying certain age and service requirements. Employer contributions to the Pension Plan are in accordance with the minimum funding requirements of the Employee Retirement Income Security Act of 1974, as amended. The Company expects to make no contribution to the Pension Plan in 2014. The Company uses a December 31 measurement date for the benefit obligations and a January 1 measurement date for its net periodic costs for the Pension Plan. Variances from actuarially assumed rates will result in increases or decreases in benefit obligations, net periodic cost and funding requirements in future periods. Benefits expense under the Pension Plan was $0.3 million, $0.3 million and $0.6 million for the years ended December 31, 2013, 2012 and 2011, respectively. The accrued benefit liability for the Pension Plan totaled $6.6 million at December 31, 2013 and $16.8 million at December 31, 2012, and is included in other long-term liabilities on the consolidated balance sheets. The weighted-average assumptions used for determining the net periodic cost for the year ended December 31, 2013 was a discount rate of 3.9%, an annual salary increase of 5.0% and the expected long-term rate of return on assets of 8.0%.

11. STOCKHOLDER'S EQUITY

Equity transactions at the Parent level are recorded as a capital contribution (distribution) from the Parent in the accompanying consolidated statements of stockholder's equity. The cash flows from equity transactions at the Parent level, including the repurchase of the Parent's stock and proceeds from the exercise of the Parent's stock options, including related excess tax benefits, are recorded as net capital contributions (distributions) in the cash flows from financing activities section of the accompanying consolidated statements of cash flows.

On December 14, 2011, the Parent adopted an open market repurchase program for up to 4,000,000 shares of the Parent's common stock, not to exceed $100 million in repurchases. The repurchase program will conclude at the earliest of three years from the commencement date, when the maximum number of shares has been repurchased, or when the maximum dollar amount of repurchases has been expended. During the year ended December 31, 2013, the Parent repurchased and retired 706,023 shares at a weighted-average price of $38.39 per share, which is the cumulative number of shares repurchased and retired under this program. No shares were repurchased under this program during the year ended December 31, 2012.

Historically, the Parent has not paid any cash dividends. In December 2012, the Parent declared and paid a special dividend of $0.25 per share to holders of its common stock at the close of business as of December 17, 2012, which totaled approximately $23.0 million. In conjunction with the Parent's payment of a special dividend, the Company paid to the Parent a cash dividend in the same amount. The Parent did not pay a cash dividend in 2013 and does not anticipate the payment of any other cash dividends in the foreseeable future. The Company's Credit Facility limits the Parent's ability to pay dividends and/or repurchase stock to an amount not to exceed $150 million in the aggregate plus the aggregate amount of proceeds from the exercise of stock options. The indentures governing the 8% Senior Notes due 2019 and the 7⅛% Senior Notes due 2020 (collectively, the "Senior Notes") and the 5⅛% Senior Secured Notes due 2018 also limit the Parent's ability to pay dividends and/or repurchase stock. As of December 31, 2013, under the most restrictive test under these agreements, the Parent has approximately $261.9 million remaining available with which to pay permitted dividends and/or make stock and Senior Notes repurchases.

CHS/COMMUNITY HEALTH SYSTEMS, INC.
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The following schedule discloses the effects of changes in the Company's ownership interest in its less-than-wholly-owned subsidiaries on CHS/Community Health Systems, Inc. stockholder's equity (in thousands):

	Year Ended December 31,		
	2013	2012	2011
Net income attributable to CHS/Community Health Systems, Inc.	$ 141,203	$ 265,640	$ 201,948
Transfers to the noncontrolling interests:			
Net decrease in CHS/Community Health Systems, Inc. paid-in capital for purchase of subsidiary partnership interests	(768)	(21,537)	(4,556)
Net transfers to the noncontrolling interests	(768)	(21,537)	(4,556)
Change to CHS/Community Health Systems, Inc. stockholder's equity from net income attributable to CHS/Community Health Systems, Inc. and transfers to noncontrolling interests	$ 140,435	$ 244,103	$ 197,392

12. EQUITY INVESTMENTS

As of December 31, 2013, the Company owned equity interests of 27.5% in four hospitals in Las Vegas, Nevada, and 26.1% in one hospital in Las Vegas, Nevada, in which Universal Health Systems, Inc. owns the majority interest, and an equity interest of 38.0% in three hospitals in Macon, Georgia, in which HCA Holdings, Inc. ("HCA") owns the majority interest.

Summarized combined financial information for these unconsolidated entities in which the Company owns an equity interest is as follows (in thousands):

	December 31,	
	2013	2012
Current assets	$ 235,679	$ 240,086
Noncurrent assets	790,297	847,484
Total assets	$ 1,025,976	$ 1,087,570
Current liabilities	$ 99,330	$ 89,933
Noncurrent liabilities	1,616	1,941
Members' equity	924,909	995,569
Noncontrolling interest	121	127
Total liabilities and equity	$ 1,025,976	$ 1,087,570

	Year Ended December 31,		
	2013	2012	2011
Revenues	$ 1,246,183	$ 1,236,915	$ 1,230,146
Operating costs and expenses	1,116,745	1,079,055	1,068,212
Income from continuing operations before taxes	129,576	157,762	162,124

The summarized financial information was derived from the unaudited financial information provided to the Company by those unconsolidated entities.

The Company's investment in all of its unconsolidated affiliates was $421.7 million and $432.1 million at December 31, 2013 and 2012, respectively, and is included in other assets, net in the accompanying consolidated balance sheets. Included in the Company's results of operations is the Company's equity in pre-tax earnings from all of its investments in unconsolidated affiliates, which was $42.6 million, $42.0 million and $49.5 million for the years ended December 31, 2013, 2012 and 2011, respectively.

13. OTHER COMPREHENSIVE INCOME

The following tables present information about items reclassified out of accumulated other comprehensive income (loss) by component for the year ended December 31, 2013 (in thousands, net of tax):

	Change in Fair Value of Interest Rate Swaps	Change in Fair Value of Available for Sale Securities	Change in Unrecognized Pension Cost Components	Accumulated Other Comprehensive Income (Loss)
Balance as of December 31, 2012	$ (116,382)	$ 4,588	$ (33,516)	$ (145,310)
Other comprehensive (loss) income before reclassifications	(3,837)	2,181	12,479	10,823
Amounts reclassified from accumulated other comprehensive income (loss)	64,141	-	2,841	66,982
Net current-period other comprehensive income	60,304	2,181	15,320	77,805
Balance as of December 31, 2013	$ (56,078)	$ 6,769	$ (18,196)	$ (67,505)

The following table presents a subtotal for each significant reclassification to net income out of accumulated other comprehensive income (loss) and the line item affected in the accompanying consolidated statement of income during the year ended December 31, 2013 (in thousands):

Details about accumulated other comprehensive income (loss) components	Amount reclassified from AOCL Year Ended December 31, 2013	Affected line item in the statement where net income is presented
Gains and losses on cash flow hedges		
Interest rate swaps	$ (99,808)	Interest expense, net
	35,667	Tax benefit
	$ (64,141)	Net of tax
Amortization of defined benefit pension items		
Prior service costs	$ (1,143)	Salaries and benefits
Actuarial losses	(3,382)	Salaries and benefits
	(4,525)	Total before tax
	1,684	Tax benefit
	$ (2,841)	Net of tax

14. COMMITMENTS AND CONTINGENCIES

Construction and Other Capital Commitments. Pursuant to a hospital purchase agreement in effect as of December 31, 2013, the Company has agreed to build a replacement facility in York, Pennsylvania. The estimated construction cost, including equipment costs, is approximately $100.0 million. This project is required to be completed in 2017 and $0.7 million has been expended through December 31, 2013 related to this replacement hospital. In October 2008, after the purchase of the noncontrolling owner's interest in the Company's Birmingham, Alabama facility, the Company initiated the purchase of a site, which includes a partially constructed hospital structure, for a potential replacement for the existing Birmingham facility. In September 2010, the Company received approval of its request for a certificate of need ("CON") from the Alabama Certificate of Need Review Board. This CON was challenged in the Alabama state circuit and appellate courts, but the CON was upheld by the Supreme Court of Alabama in May 2013, eliminating any further appeals. The Company's estimated construction costs, including the acquisition of the site and equipment costs, are approximately $280.0 million for the Birmingham replacement facility. Of this amount, approximately $64.2 million has been expended through December 31, 2013. In addition, under other purchase agreements outstanding at December 31, 2013, the Company has committed to spend approximately $393.5 million for costs such as capital improvements, equipment, selected leases and physician recruiting. These commitments are required to be fulfilled generally over a five to seven year period after acquisition. Through December 31, 2013, the Company has spent approximately $256.8 million related to these commitments.

Physician Recruiting Commitments. As part of its physician recruitment strategy, the Company provides income guarantee agreements to certain physicians who agree to relocate to its communities and commit to remain in practice there. Under such agreements, the Company is required to make payments to the physicians in excess of the amounts they earned in their practice up to the amount of the income guarantee. These income guarantee periods are typically for 12 months. Such payments are recoverable by the Company from physicians who do not fulfill their commitment period, which is typically three years, to the respective community. At December 31, 2013, the maximum potential amount of future payments under these guarantees in excess of the liability recorded is $20.9 million.

Professional Liability Claims. As part of the Company's business of owning and operating hospitals, it is subject to legal actions alleging liability on its part. The Company accrues for losses resulting from such liability claims, as well as loss adjustment expenses that are out-of-pocket and directly related to such liability claims. These direct out-of-pocket expenses include fees of outside counsel and experts. The Company does not accrue for costs that are part of corporate overhead, such as the costs of in-house legal and risk management departments. The losses resulting from professional liability claims primarily consist of estimates for known claims, as well as estimates for incurred but not reported claims. The estimates are based on specific claim facts, historical claim reporting and payment patterns, the nature and level of hospital operations and actuarially determined projections. The actuarially determined projections are based on the Company's actual claim data, including historic reporting and payment patterns which have been gathered over an approximate 20-year period. As discussed below, since the Company purchases excess insurance on a claims-made basis that transfers risk to third-party insurers, the liability it accrues does include an amount for the losses covered by its excess insurance. The Company also records a receivable for the expected reimbursement of losses covered by excess insurance. Since the Company believes that the amount and timing of its future claims payments are reliably determinable, it discounts the amount accrued for losses resulting from professional liability claims using the risk-free interest rate corresponding to the timing of expected payments.

The net present value of the projected payments was discounted using a weighted-average risk-free rate of 1.6%, 1.2% and 1.2% in 2013, 2012 and 2011, respectively. This liability is adjusted for new claims information in the period such information becomes known. The Company's estimated liability for professional and general liability claims was $643.9 million and $621.7 million as of December 31, 2013 and 2012, respectively. The estimated undiscounted claims liability was $686.9 million and $649.4 million as of December 31, 2013 and 2012, respectively. The current portion of the liability for professional and general liability claims was $104.4 million and $106.9 million as of December 31, 2013 and 2012, respectively, and is included in other accrued liabilities in the accompanying consolidated balance sheets. Professional malpractice expense includes the losses resulting from professional liability claims and loss adjustment expense, as well as paid excess insurance premiums, and is presented within other operating expenses in the accompanying consolidated statements of income.

The Company's processes for obtaining and analyzing claims and incident data are standardized across all of its hospitals and have been consistent for many years. The Company monitors the outcomes of the medical care services that it provides and for each reported claim, the Company obtains various information concerning the facts and circumstances related to that claim. In addition, the Company routinely monitors current key statistics and volume indicators in its assessment of utilizing historical trends. The average lag period between claim occurrence and payment of a final settlement is between four and five years, although the facts and circumstances of individual claims could result in the timing of such payments being different from this average. Since claims are paid promptly after settlement with the claimant is reached, settled claims represent less than 1.0% of the total liability at the end of any period.

For purposes of estimating its individual claim accruals, the Company utilizes specific claim information, including the nature of the claim, the expected claim amount, the year in which the claim occurred and the laws of the jurisdiction in which the claim occurred. Once the case accruals for known claims are determined, information is stratified by loss layers and retentions, accident years, reported years, geography and claims relating to the acquired Triad hospitals versus claims relating to the Company's other hospitals. Several actuarial methods are used against this data to produce estimates of ultimate paid losses and reserves for incurred but not reported claims. Each of these methods uses company-specific historical claims data and other information. This company-specific data includes information regarding the Company's business, including historical paid losses and loss adjustment expenses, historical and current case loss reserves, actual and projected hospital statistical data, a variety of hospital census information, employed physician information, professional liability retentions for each policy year, geographic information and other data.

Based on these analyses the Company determines its estimate of the professional liability claims. The determination of management's estimate, including the preparation of the reserve analysis that supports such estimate, involves subjective judgment of the management. Changes in reserving data or the trends and factors that influence reserving data may signal fundamental shifts in the Company's future claim development patterns or may simply reflect single-period anomalies. Even if a change reflects a fundamental shift, the full extent of the change may not become evident until years later. Moreover, since the Company's methods and models use different types of data and the Company selects its liability from the results of all of these methods, it typically cannot quantify the precise impact of such factors on its estimates of the liability. Due to the Company's standardized and consistent processes for handling claims and the long history and depth of company-specific data, the Company's methodologies have produced reliably determinable estimates of ultimate paid losses.

The Company is primarily self-insured for these claims; however, the Company obtains excess insurance that transfers the risk of loss to a third-party insurer for claims in excess of self-insured retentions. The Company's excess insurance is underwritten on a claims-made basis. For claims reported prior to June 1, 2002, substantially all of the Company's professional and general liability risks were subject to a $0.5 million per occurrence self-insured retention and for claims reported from June 1, 2002 through June 1, 2003, these self-insured retentions were $2.0 million per occurrence. Substantially all claims reported after June 1, 2003 and before June 1, 2005 are self-insured up to $4.0 million per claim. Substantially all claims reported on or after June 1, 2005 are self-insured up to $5.0 million per claim. Management on occasion has selectively increased the insured risk at certain hospitals based upon insurance pricing and other factors and may continue that practice in the future. Excess insurance for all hospitals has been purchased through commercial insurance companies and generally covers the Company for liabilities in excess of the self-insured retentions. The excess coverage consists of multiple layers of insurance, the sum of which totals up to $95.0 million per occurrence and in the aggregate for claims reported on or after June 1, 2003, up to $145.0 million per occurrence and in the aggregate for claims reported on or after June 1, 2008 and up to $195.0 million per occurrence and in the aggregate for claims incurred and reported after January 1, 2010. For certain policy years, if the first aggregate layer of excess coverage becomes fully utilized, then the Company's self-insured retention could increase to $10 million per claim for any subsequent claims in that policy year until the Company's total aggregate coverage is met.

Effective January 1, 2008, the former Triad hospitals are insured on a claims-made basis as described above and through commercial insurance companies as described above for substantially all claims occurring on or after January 1, 2002 and reported on or after January 1, 2008. Substantially all losses for the former Triad hospitals in periods prior to May 1999 were insured through a wholly-owned insurance subsidiary of HCA, Triad's owner prior to that time, and excess loss policies maintained by HCA. HCA has agreed to indemnify the former Triad hospitals in respect of claims covered by such insurance policies arising prior to May 1999. After May 1999 through December 31, 2006, the former Triad hospitals obtained insurance coverage on a claims incurred basis from HCA's wholly-owned insurance subsidiary, with excess coverage obtained from other carriers that is subject to certain deductibles. Effective for claims incurred after December 31, 2006, Triad began insuring its claims from $1 million to $5 million through its wholly-owned captive insurance company, replacing the coverage provided by HCA. Substantially all claims occurring during 2007 were self-insured up to $10 million per claim.

Legal Matters. The Company is a party to various legal proceedings incidental to its business. In the opinion of management, any ultimate liability with respect to these actions will not have a material adverse effect on the Company's consolidated financial position, cash flows or results of operations. With respect to all litigation matters, the Company considers the likelihood of a negative outcome. If the Company determines the likelihood of a negative outcome is probable and the amount of the loss can be reasonably estimated, the Company records an estimated loss for the expected outcome of the litigation and discloses that fact together with the amount accrued, if it was estimable. If the likelihood of a negative outcome is reasonably possible and the Company is able to determine an estimate of the possible loss or a range of loss, the Company discloses that fact together with the estimate of the possible loss or range of loss. However, it is difficult to predict the outcome or estimate a possible loss or range of loss in some instances because litigation is subject to significant uncertainties.

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Probable Contingencies

Department of Justice Investigation of Medicare Short-Stay Admissions from Emergency Departments

In April 2011, the Company received a document subpoena from the United States Department of Health and Human Services ("OIG") in connection with an investigation of possible improper claims submitted to Medicare and Medicaid. The subpoena was directed to all of the Company's hospitals and requested documents concerning emergency department processes and procedures, including the hospitals' use of the Pro-MED Clinical Information System, a third-party software system that assists with the management of patient care and provides operational support and data collection for emergency department management. The subpoena also sought information about the Company's relationships with emergency department physicians, including financial arrangements. This investigation is being led by the Department of Justice. The Company is continuing to cooperate with the government with the ongoing document production, as well as conducting a joint medical necessity review of a sampling of medical records at a small number of hospitals. In 2013, the Company has met with the government twice to review and discuss the investigation. On July 9, 2013, shortly after a second meeting with the government, the Company was served with an additional document subpoena, as well as civil investigative demands to interview two of the Company's current executives. In further discussions with the government, these additional requests do not reflect an expansion of the pending investigation. The Company will continue to cooperate with the government in their investigative efforts.

We are currently in negotiations with the Department of Justice about resolving its claims in connection with its investigation into the Company's short stay hospital admissions for the years 2005-2010, as well as their investigation at our hospital in Laredo, Texas. Based on those negotiations, which are not final, we believe that a reserve of $101.5 million is sufficient to cover the federal government's claims for Medicare, Tricare, and Medicaid admissions (including the claims described in the Legal Proceedings section in Part I Item 3 of this Form 10-K related to United States ex rel. and Reuille vs. Community Health Systems Professional Services Corporation and Lutheran Musculoskeletal Center, LLC d/b/a Lutheran Hospital (United States District Court for the Northern District of Indiana, Fort Wayne Division) and the May 2011 subpoena identified as "Shelbyville, Tennessee OIG Subpoena"), certain claims specifically related to our hospital in Laredo, Texas, and on other related legal expenses. This reserve is not meant to include third party legal expenses. The Company is also negotiating a corporate integrity agreement with the Office of the Inspector General of the Department of Health and Human Services.

There are a number of legal matters for which, based on information currently available, the Company believes that a negative outcome is known or is probable. In the aggregate, including the matter above, an estimate of these losses has been accrued in the amount of $118.7 million and $22.6 million at December 31, 2013 and 2012, respectively, and is included in other accrued liabilities in the accompanying consolidated balance sheets. Due to the uncertainties and difficulty in predicting the ultimate resolution of these contingencies, the actual amount could differ from the estimated amount; however, the Company does not believe a change in estimate for any of these matters would be material.

The table below presents a reconciliation of the beginning and ending liability balances in connection with probable contingencies recorded during the years ended December 31, 2013 and 2012 (in thousands):

	December 31,	
	2013	2012
Balance, beginning of year	$ 22,612	$ 10,562
Government settlement and related costs	101,500	-
Other legal settlements	4,654	27,538
Cash payments	(10,049)	(15,488)
Balance, end of year	$ 118,717	$ 22,612

Other costs incurred related to probable contingencies, including attorneys' fees, totaled $8.5 million and $12.5 million for the years ended December 31, 2013 and 2012, respectively, and is included in other operating expenses in the accompanying consolidated statements of income.

Reasonably Possible Contingencies

For the legal matter below, the Company believes that a negative outcome is reasonably possible, but the Company is unable to determine an estimate of the possible loss or a range of loss.

U.S. ex rel. Baker vs. Community Health Systems, Inc. (United States District Court for the District of New Mexico)

The Company's knowledge of this matter originated in early 2006 with correspondence from the Civil Division of the Department of Justice requesting documents in an investigation it was conducting involving the Company. The inquiry related to the way in which different state Medicaid programs apply to the federal government for matching or supplemental funds that are ultimately used to pay for a small portion of the services provided to Medicaid and indigent patients. These programs are referred to by different names, including "intergovernmental payments," "upper payment limit programs," and "Medicaid disproportionate share hospital payments." For approximately three years, the Company provided the Department of Justice with requested documents, met with its personnel on numerous occasions and otherwise cooperated in its investigation. During the course of the investigation, the Civil Division notified the Company that it believed that the Company and three of its New Mexico hospitals caused the State of New Mexico to submit improper claims for federal funds, in violation of the Federal False Claims Act. This investigation has culminated in the federal government's intervention in the referenced qui tam lawsuit, which alleges that the Company's New Mexico hospitals "caused to be filed" false claims from the period of August 2000 through June 2011. Two of the parent company's subsidiaries are also defendants in this lawsuit. The Company continues to vigorously defend this action. On December 4-5, 2013, the district court judge heard oral arguments on both sides' motions for summary judgment. By telephone conference on December 19, 2013, he advised the parties that, with respect to the core motions for summary judgment, he was denying all parties' motions, concluding that there were issues of fact to be determined at trial. Court ordered mediation has been set for March 12, 2014 and a trial date of October 14, 2014 has been assigned.

Matters for which an Outcome Cannot be Assessed

For all of the legal matters below, the Company cannot at this time assess what the outcome may be and is further unable to determine any estimate of loss or range of loss. Because the investigations are at a preliminary stage, there are not sufficient facts available to make these assessments.

Multi-provider National Department of Justice Investigations

Implantable Cardioverter Defibrillators ("ICDs"). The Company was first made aware of this investigation in September 2010, when the Company received a letter from the Civil Division of the United States Department of Justice. The letter advised the Company that an investigation was being conducted to determine whether certain hospitals have improperly submitted claims for payment for ICDs. The period of time covered by the investigation was 2003 to 2010. The Company continues to fully cooperate with the government in this investigation and has provided requested records and documents. On August 30, 2012, the Department of Justice issued a document entitled, "Medical Review Guidelines/Resolution Model," which sets out, for the purposes of this investigation, the patient conditions and criteria for the medical necessity of the implantation of ICDs in Medicare beneficiaries and how the Department of Justice will enforce the repayment obligations of hospitals. The Company is in the process of reviewing its medical records in light of the guidance contained in this document.

Class Action Shareholder Federal Securities Cases. Three purported class action cases have been filed in the United States District Court for the Middle District of Tennessee; namely, Norfolk County Retirement System v. Community Health Systems, Inc., et al., filed May 9, 2011; De Zheng v. Community Health Systems, Inc., et al., filed May 12, 2011; and Minneapolis Firefighters Relief Association v. Community Health Systems, Inc., et al., filed June 21, 2011. All three seek class certification on behalf of purchasers of the Parent's common stock between July 27, 2006 and April 11, 2011 and allege that misleading statements resulted in artificially inflated prices for the Parent's common stock. In December 2011, the cases were consolidated for pretrial purposes and NYC Funds and its counsel were selected as lead plaintiffs/lead plaintiffs' counsel. The Company's motion to dismiss this case has been fully briefed and is pending before the court. The Company believes this consolidated matter is without merit and will vigorously defend this case.

Shareholder Derivative Actions. Three purported shareholder derivative actions have also been filed in the United States District Court for the Middle District of Tennessee; Plumbers and Pipefitters Local Union No. 630 Pension Annuity Trust Fund v. Wayne T. Smith, et al., filed May 24, 2011; Roofers Local No. 149 Pension Fund v. Wayne T. Smith, et al., filed June 21, 2011; and Lambert Sweat v. Wayne T. Smith, et al., filed October 5, 2011. These three cases allege breach of fiduciary duty arising out of allegedly improper inpatient admission practices, mismanagement, waste and unjust enrichment. These cases have been consolidated into a single, consolidated action. The plaintiffs filed an operative amended derivative complaint in these three consolidated actions on March 15, 2012. The Company's motion to dismiss was argued on June 13, 2013. On September 27, 2013, the court issued an order granting in part and denying in part the Company's motion to dismiss. On October 14, 2013, the Company filed for a Motion for Reconsideration of the Order Granting in Part and Denying in Part the Motion to Dismiss, a Motion to Stay Discovery, and an unopposed Motion for Extension of Time to File an Answer. The Company believes all of the plaintiffs' claims are without merit and will vigorously defend them.

15. SUBSEQUENT EVENTS

The Company evaluated all material events occurring subsequent to the balance sheet date though March 5, 2014, the date the consolidated financial statements were issued, for events requiring disclosure or recognition in the consolidated financial statements.

On January 27, 2014, the Company completed the acquisition of HMA. Pursuant to the merger agreement governing the transaction, the Company acquired all the outstanding shares of HMA's common stock for approximately $7.6 billion, including the assumption of approximately $3.7 billion of existing indebtedness, for consideration for each share of HMA's common stock consisting of $10.50 in cash, 0.06942 of a share of the Company's common stock, and one contingent value right ("CVR"). The CVR entitles the holder to receive a cash payment of up to $1.00 per CVR (subject to downward adjustment), subject to the final resolution of certain legal matters pertaining to HMA, as defined in the CVR agreement.

In connection with the HMA merger, the Company entered into a third amendment and restatement of the Credit Facility, providing for additional financing and recapitalization of certain of the Company's term loans, including (i) the replacement of the revolving credit facility with a new $1.0 billion revolving facility maturing 2019 (the "Revolving Facility"), (ii) the addition of a new $1.0 billion Term A facility due 2019 (the "Term A Facility"), (iii) a Term D facility in an aggregate principal amount equal to approximately $4.602 billion due 2021 (which includes certain term loans due 2017 that were converted into such Term D facility (collectively, the "Term D Facility")), (iv) the conversion of certain term loans due 2017 into Term E Loans and the borrowing of new Term E Loans due 2017 in an aggregate principal amount of approximately $1.677 billion (collectively, the "Term E Facility" and, together with the Revolving Facility, the Term D Facility and the Term A Facility, the "Credit Facilities") and (v) the addition of flexibility commensurate with the Company's post-acquisition structure. In addition to funding a portion of the consideration in connection with the HMA merger, some of the proceeds of the Term A Facility and Term D Facility were used to refinance the outstanding $637.5 million existing Term A facility due 2016 and the $59.6 million of term loans due 2014, respectively.

Adjusted for the effect of this amendment and restatement of the Company's Credit Facility, the term loans are scheduled to be paid with principal payments for future years as follows $112.8 million due in 2014, $162.8 million due in 2015, $162.8 million due in 2016, $1.822 billion due in 2017, $496.0 million due in 2018 and $4.521 billion due thereafter.

In connection with the financing activities of the HMA merger, the Company, through one of its wholly-owned subsidiaries, also issued: (i) $1.0 billion aggregate principal amount of 5.125% Senior Secured Notes due 2021 (the "Secured Notes") and (ii) $3.0 billion aggregate principal amount of 6.875% Senior Notes due 2022 (the "Unsecured Notes" and, together with the Secured Notes, the "Notes"). The Secured Notes are senior secured obligations of the Company and are guaranteed on a senior secured basis by the Parent and by the Company and certain of its subsidiaries. The Secured Notes mature on August 1, 2021, and bear interest at a rate of 5.125% per annum. The Unsecured Notes are senior unsecured obligations of the Company and are guaranteed on a senior basis by the Parent and certain of the Company's subsidiaries. The Unsecured Notes mature on February 1, 2022, and bear interest at a rate of 6.875% per annum.

The initial accounting for the acquisition of HMA is currently incomplete. The Company is in the process of obtaining initial information relative to the fair values of assets acquired, liabilities assumed and any noncontrolling interests in the transaction. The valuation of the acquired assets and assumed liabilities will include, but not be limited to, fixed assets, Medicare licenses, certificates of need, other potential intangible assets and contingencies. The valuations will consist of physical inspections and appraisal reports, discounted cash flow analyses, or other appropriate valuation techniques to determine the fair value of the assets acquired or liabilities assumed.

On February 5, 2014, the Company announced that one or more subsidiaries of the Company have executed a definitive agreement to acquire substantially all of the assets of Sharon Regional Health System in Sharon, Pennsylvania for approximately $70 million, plus net working capital. Sharon Regional Health System includes a 251-bed acute care hospital and other outpatient and ancillary services.

Attachment C.Orderly Development.7.d

Tennova™
Healthcare

November 26, 2013

Ms. Karen L. Kirby, R.N.
Regional Administrator
ETRO Health Care Facilities
East Tennessee Region
5904 Lyons View Pike, Bldg. 1
Knoxville, TN 37917

RE: 44-5360

Dear Ms. Kirby,

Attached please find our plan of correction for the November 12- 14, 2013 annual survey.

Thank you,

Pamela B. Rogers

Pamela B. Rogers, Administrator

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
OFFICE OF HEALTH LICENSURE AND REGULATION
EAST TENNESSEE REGION
5904 LYONS VIEW PIKE, BLDG. 1
KNOXVILLE, TENNESSEE 37919

IMPORTANT NOTICE - PLEASE READ CAREFULLY

November 19, 2013

Ms. Pamela Rogers, Administrator
Tennova Transitional Care Unit
900 E. Oak Hill Avenue
Knoxville TN 37917

RE: 44-5360

Dear Ms. Rogers:

The East Tennessee Regional Office of Health Care Facilities conducted a Health and Life Safety Code recertification survey on November 12 - 14, 2013. This letter to you is to serve as notice that as a result of the survey completed **November 14, 2013,** your facility was not in substantial compliance with the participation requirements of Medicare and/or Medicaid Programs. A statement of deficiencies (CMS 2567) is being provided to you with this letter.

If you do not achieve substantial compliance by **December 29, 2013** (45th day), our office will recommend to the Centers for Medicare & Medicaid Services (CMS) and/or the State Medicaid Agency that enforcement remedies be imposed.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Mandatory Remedies

If you do not achieve substantial compliance by **February 14, 2014,** (3 months after the last day of the survey identifying noncompliance **November 14, 2013**), the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We will also recommend to the CMS Regional Office that your Provider Agreement be terminated on **May 14, 2014,** if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

Plan of Correction (POC)

A POC for the deficiencies must be submitted by **November 29, 2013.** Failure to submit an acceptable POC by **November 29, 2013,** may result in the imposition of remedies by **December 29, 2013.**

Your POC must contain the following:

What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur; and

How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place.

INFORMAL DISPUTE RESOLUTION

In accordance with 488.331, you have one opportunity to question cited deficiencies. You may request a Face to Face IDR for substandard level deficiencies, harm level deficiencies and immediate jeopardy level deficiencies. All other deficiencies will receive a desk review (telephone or written) by the Regional Office that cited the deficiency. These requests must be made within the same 10-calendar day period that you have for submitting an acceptable plan of correction and must contain additional justification as to why the deficiency(ies) should not have been written for harm level deficiencies or other deficiencies that are not substandard or immediate jeopardy. Evidence to dispute the scope and severity levels may only be submitted for substandard or immediate jeopardy deficiencies. Additional information which must be submitted with your request for an IDR is limited to no more than five (5) typed pages with a font size of no less than ten (10). If the facility is requesting a desk review in addition to a face to face IDR, the facility must submit two separate requests with their plan of correction to the State Survey Agency at the address on this letter, telephone 865-588-5656 or fax number 865-594-5739. An incomplete Informal Dispute Resolution process will not delay the effective date of any enforcement action.

If you have any questions, please contact the East Tennessee Regional Office by phone: 865-588-5656 or by fax: 865-594-5739.

Sincerely,

Karen B. Kirby

Karen B. Kirby, R.N.
Regional Administrator
ETRO Health Care Facilities

KK:afl

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445360	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNOVA HEALTH CARE-TENNOVA TCU	900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 SS=D	483.10(b)(1) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility protocol, and interview, the facility failed to notify the physician of the development of a stage two	F 157	**F157** 1. Resident 143 was a closed record. 2. November 22, 2013 all records of 100% of current residents were audited to ensure proper physician, resident, resident's legal representative or interested family have been notified of any significant changes in the resident's condition. As a result of the audit, no residents were found to be affected by the deficient practice. 3. A. All staff will receive education related to proper physician, resident, resident's legal representative or interested family notification of any significant changes in the resident's condition by no later than December 15, 2013. B. Physician, Physician Extender education will be conducted related to proper physician, resident, resident's legal representative or interested family notification of any significant changes in the resident's condition by no later than December 15, 2013. C. A Physician Notification of Change in Condition sheet will be added as part of medical record documentation. This document will serve as notification to the physician/ physician extender of any noted changes in the condition of the resident. It will be placed in the Progress Notes for the physician/ physician extender to address accordingly. Also included on this document will be verification the resident, legal representative or interested family have been notified. Staff and Physician, Physician Extender education will be conducted and the document implemented for use by December 15, 2013.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela R. Lee RN/MSN	NHA	11/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued from page 1 pressure ulcer for one resident (#143) of six residents reviewed for pressure ulcer of twenty residents reviewed. The findings included: Resident #143 was admitted to the facility on September 6, 2013, with diagnoses including Diabetes, Hypertension, Autoimmune Idiopathic Immune-Mediated Thrombocytopenia, Pulmonary Contusion, Status Post Motor Vehicle Accident, and Multiple Fractures. Medical record review of a nurse's note dated September 11, 2013, revealed "...2nd (second) stage area noted..." Medical record review revealed no documentation the physician had been notified of the development of the Stage II pressure ulcer. Review of facility protocol, Wound and Skin Care, revealed "Protocol...Stage Two Pressure Ulcer: Needs MD Order..." Interview with the Director of Nursing on November 14, 2013, at 12:45 p.m., in the conference room confirmed 2nd stage area noted is Stage II pressure ulcer. Continued interview with the Director of Nursing on November 14, 2013, at 12:50 p.m., in the conference room, confirmed the pressure ulcer was identified on September 11, 2013. Further interview confirmed the physician had not been notified timely of the development of the pressure ulcer and no orders were received until September 14, 2013.	F 157	4. A. Random monthly audits of 20% of resident charts will be conducted starting in December 2013, to continue thereafter. B. All staff will receive annual education related to proper physician, resident, resident's legal representative or interested family notification of any significant changes in the resident's condition on an annual basis as part of the mandatory Annual Review required for nursing staff.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 278	Continued From page 2 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure the Admission Minimum Data Set (MDS) was accurate for one resident (#143) of twenty residents reviewed. The findings included:	F 278	**F278** 1. On November 25, 2013 a *Section X Correction Request* was submitted to CMS to address the Coding Error related to the missing Stage II PrU noted on September 11, 2013 (Resident 143). 2. An audit of MDS's November 22-25, 2013 revealed no further inaccurate assessments. 3. A. Patient Care Conference each Tuesday at 2:00 p.m. will consist of MDS review by team for accuracy. B. Documentation will be revised by December 15, 2013 to include enhance the ability to correctly code for MDS accuracy. This documentation will include revised Nursing Notes and Physician Notification of Change in Condition. C. All staff will be educated on how to utilize and document on the revised documentation by December 20, 2013. 4. Random monthly audits of 20% of resident MDS will be conducted to monitor for accuracy starting in December 2013, to continue thereafter.	

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F 278	Continued F om page 3 Resident #1 3 was admitted to the facility on September (, 2013, with diagnoses including Diabetes, H pertension, Autoimmune Idiopathic Immune-Me liated Thrombocytopenia, Pulmonary Contusion, S tatus Post Motor Vehicle Accident, and Multiple Fractures. Medical rec rd review of a nurse's note dated September 1, 2013, revealed "... 2nd (second) stage area (Stage II pressue ulcer) noted..." Medical rec rd review of the Admission MDS dated Septe nber 13, 2013, revealed no documentati on of the Stage II pressure ulcer. Interview wil the Director of Nursing on November 1 , 2013, at 12:50 p.m., in the conference room confirmed the Admission MDS dated Septe nber 13, 2013, did not include the Stage II pres sure ulcer.	F 278	**F281** 1. Residents identified who were present in the facility and not discharged and lacked appropriate Care Plans, were assessed and individualized Care Plans were initiated. 2. November 22, 2013 all records of 100% of current residents were audited to ensure admission Care Plans included necessary actual/potential problems, goals and approaches. Any residents identified to have Care Plan needs which were not documented were corrected and Care Plans were initiated. 3. A. Patient Care Conference each Tuesday at 2:00 p.m. will consist of Care Plan review by team for accuracy. B. Documentation will be revised by December 15, 2013 to include enhance the ability to identify Care Plan needs. This documentation will include revised Nursing Notes and Physician Notification of Change in Condition. C. All staff will be educated on how to utilize and document on the revised documentation by December 20, 2013. 4. Random monthly audits of 20% of resident Care Plans will be conducted to monitor for individualization and addressing of actual/ potential problems starting in December 2013, to continue thereafter.	
F 281 SS=E	483.20(k)(3) i) SERVICES PROVIDED MEET PROFESSIC NAL STANDARDS The service provided or arranged by the facility must meet p ofessional standards of quality. This REQUI REMENT is not met as evidenced by: Based on m edical record review, observation, and intervie , the facility failed to develop an Admission C are Plan to address dental needs, depression, kin care, nutritional needs, psychotropic medications, dehydration, anticoagular therapy, or pain control for seven (#182, #185, #140, #152, #188, #186, #180) of twenty reside nts reviewed.	F 281		

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F 281	Continued From page 4 The findings included: Resident #132 was admitted to the facility on November 8, 2013, with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Pain Syndrome, Diabetes Mellitus, Hypertension, Depression, Anxiety, Degenerative Joint Disease, Hyperlipidemia, Peripheral Vascular Disease, and History of Pulmonary Embolism. Medical record review of the Nutrition Assessment dated November 11, 2013, revealed the resident had difficulty with chewing or swallowing, had missing teeth, and received a 2000 calorie diet. Medical record review of a hospital History and Physical dated October 29, 2013, revealed "...has chronic pain syndrome and takes narcotics...was given Narcan (antidote for narcotics)..." Medical record review of the facility's History and Physical dated November 8, 2013, revealed "...chronic pain syndrome...depression, anxiety...feels very depressed...Medications: At the present time...Trazodone (antidepressant) 100 mg (milligrams) p.o. (by mouth) at bedtime...Morphine extended release 50 mg p.o. 4 times a day...Altered mental status secondary to excessive narcotics. Currently, much more clear...does have chronic pain syndrome..." Medical record review of the Admission Care Plan dated November 8, 2013, revealed no documentation to address the resident's dental needs, depression, or pain control. Observation and interview with the resident on November 18, 2013, at 1:45 p.m., revealed the	F 281		

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F 281	Continued From page 5 resident lying on the bed, in the resident's room, and stated "My teeth hurt at times and are broken." Observation revealed the resident had three upper teeth and stated had "broken lower teeth." Continued interview with the resident revealed the resident had difficulty chewing due to missing teeth. Interview with the Director of Nursing on November 14, 2013, at 10:10 a.m., in the conference room confirmed an Admission Care Plan had not been developed to address the resident's dental needs, depression, or pain. Resident #135 was admitted to the facility on November 9, 2013, with diagnoses including Open Reduction and Internal Fixation of the Right Distal Femur, and Right Humeral Head Fracture. Medical record review of the nursing notes dated November 10, 2013, revealed the resident required extensive assistance of two or more persons for bed mobility and transfers. Medical record review revealed no documentation of the total score of the Braden Scale for Predicting Pressure Ulcer Risk had been completed to determine the resident's risk for development of pressure ulcers. Medical record review of the Admission Care Plan dated November 9, 2013, revealed no documentation to address the resident's risk for the potential for the development of skin issues. Observation with Licensed Practical Nurse (LPN) #1 on November 14, 2013, at 3:45 p.m., revealed the resident lying on the bed. Continued observation revealed two staff members assisted	F 281		

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F 281	Continued from page 6 the resident to turn to the left side revealing the right leg had an immobilizer brace in place. Continued observation revealed a reddened area on the buttocks described as "blanchable." Interview with the Director of Nursing and the Administrator on November 14, 2013, at 2:50 p.m., in the nursing station revealed the resident was at risk for the development of pressure ulcers and confirmed the Admission Care Plan did not address the resident's risk for skin breakdown. Resident #140 was admitted to the facility on July 25, 2013, with diagnoses including Rhabdomyolysis, Hypertension, and Dehydration. The resident was discharged on August 1, 2013. Medical record review of the hospital History and Physical dated July 22, 2013, revealed "...weakness, likely secondary to dehydration...will hydrate..." Medical record review of the Discharge Summary from the hospital dated July 25, 2013, revealed "...electrolytes within normal limits...did not develop any renal dysfunction..." Medical record review of the Admission Care Plan dated July 25, 2013, revealed the Admission Care Plan had not been developed to include dehydration/fluid maintenance. Interview with the Director of Nursing (DON), on November 14, 2013, at 9:20 a.m., in the conference room confirmed the Admission Care Plan had not been developed for the dehydration.	F 281		

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F 281	Continued from page 7 Resident #52 was admitted to the facility on August 29, 2013, with diagnoses including Chronic Kidney Disease, Hypertension, Coronary Artery Disease, and Hyperlipidemia. The resident was discharged on September 17, 2013. Medical record review revealed no Admission Care Plan had been developed for the resident. Interview with the DON on November 13, 2013, at 1:15 p.m., in the conference room confirmed an Admission Care Plan had not been developed for the resident. Resident #188 was admitted to the facility on November 4, 2013, with diagnoses including Cerebrovascular Accident, Hypertension, Dementia, and Anxiety. Medical record review of the physician's orders dated November 4, 2013, revealed "...Risperidone (antipsychotic) 0.25 mg (milligrams) ..oral twice a day...citalopram (antidepressant) 40mg oral once a day..." Medical record review of the Admission Care Plan dated November 4, 2013, revealed no development on the Admission Care Plan for the use of psychotropic drugs. Medical record review of the Braden scale score dated November 4, 2013, revealed the resident was at risk for the development of pressure ulcers. Medical record review of the Admission Care Plan dated November 4, 2013, revealed no care plan had been developed for the potential alteration in skin integrity.	F 281		

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F 281	Continued From page 8 Interview with Registered Nurse #3, on November 14, 2013, at 9:15 a.m., in the Minimum Data Set (MDS) office confirmed the Admission Care Plan had not been developed to include the psychotropic drug use. Interview with the DON on November 14, 2013, at 3:10 p.m., in the conference room confirmed the resident was at risk fo the development of pressure ulcers and the Admission Care Plan had not been developed for the potential alteration in skin integrity. Resident #136 was admitted to the facility on October 31, 2013, with diagnoses including Acute Respiratory Failure, Exacerbation of Chronic Obstructive Pulmonary Disease, with history of Coronary Artery Disease with Coronary Artery Bypass Grafting, Atrial Fibrillation, Peripheral Vascular Disease, Diabetes Mellitus, and Decubitus Ulcers. Observation and interview with the resident in the resident's room on November 12, 2013, at 10:55 a.m., revealed the resident lying on the back and complaining of pain in the legs. Medical record review of the Medication Administration Record dated November 2013 revealed the resident received Hydrocodone 5 milligrams every 4 hours as needed. Medical record review revealed the resident received the narcotic pain medication at least twice daily. Medical record review revealed no Admission Care Plan had been developed to address pain. Medical record review of the Physicians orders	F 281		

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F 281	Continued From page 9 dated October 31, 2013, revealed an order for Pradaxa (anticoagulant/blood thinner) 150 milligrams twice a day. Medical record review of the electronic Medication Administration Record revealed the resident had received the Anticoagulant as ordered. Medical record review revealed no Admission Care Plan had been developed to address the issue of the Anticoagulant or risk of bleeding. Interview with the Director of Nursing in the hallway charting area, on November 13, 2013, at 2:40 p.m., confirmed the facility had failed to develop a care plan to address the risk of bleeding and pain. Resident# 10 was admitted to the facility on November 9, 2013, with diagnoses of Epidural Abscess, Cervical Osteomyelitis, Chronic Obstructive Pulmonary Disease, and Endocarditis Medical record review of the resident's admission care plan dated November 9 ,2013, revealed no care plan for dental care or nutrition. Medical record review of the nursing admission assessment dated November 9, 2013, revealed "...oral assessment: very poor dentation, dietary referral: yes..." Medical record review of a dietary admission note dated November 11, 2013, revealed "...appetite very good, admission weight of 139.5# (pounds), height 76" (inches), BMI (body mass index, normal values are 22 and above) 21.8; IBW (ideal body weight) 148; moderate nutritional risk > (less than) 75% (percent) of meals consumed..."	F 281		

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F 281	Continued From page 10 Interview with the resident on November 13, 2013, at 2:0[illegible] p.m., in the resident's room revealed the resident had been missing many teeth for 18 years. Interview with the DON on November 13, 2013, at 3:05 p.m., in the conference room confirmed the resident had not been care planned for nutrition or dental status.	F 281	**F314** 1. A. Physician orders were obtained for any resident identified, that was still present in the facility and not discharged, who were receiving facility protocol for pressure ulcers. B. The dietician was alerted to initiate an assessment. C. Pressure ulcer risk assessments were completed for identified residents still in the facility and not discharged.	
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the facility policy, review of facility protocol, observation, and interview, the facility failed to properly assess pressure ulcers, failed to follow facility protocol for notifying the dietician for a resident with a pressure ulcer, failed to obtain physician's orders for the treatment of a pressure ulcer, and failed to complete a pressure ulcer risk assessment for four (#152, #143, #186, #185) of six residents reviewed for pressure ulcers of twenty residents reviewed.	F 314	2. November 22, 2013 all records of 100% of current residents were audited to ensure any resident with skin integrity problems, actual or potential, had physician orders for treatments, dietician consults and Pressure Ulcer Risk Assessments. 3. A. Patient Care Conference each Tuesday at 2:00 p.m. will consist a review of skin integrity problems, actual or potential by team to ensure any resident with skin integrity problems, actual or potential, had physician orders for treatments, dietician consults and Pressure Ulcer Risk Assessments. B. Documentation will be revised by December 15, 2013 to include a weekly skin audit, Physician Notification of Change in Resident Condition, dietary consults and Physician Orders. C. All staff will be educated on how to properly assess, plan, implement and document skin care on the revised documentation by December 20, 2013. 4. Random monthly audits of 20% of resident records will be conducted to monitor for Physician Notification of Change in Condition, Physician Orders and Dietary Consults starting in December 2013, to continue thereafter.	

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	445360	A. BUILDING _____ B. WING _____	11/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNOVA HEALTH CARE-TENNOVA TCU	900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

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F 314	Continued From page 11 The findings included: Resident #152 was admitted to the facility on August 29, 2013, with diagnoses including Chronic Kidney Disease, Hypertension, Coronary Artery Disease, Debility, and Hyperlipidemia. The resident was discharged on September 17, 2013. Medical record review of a nursing note dated September 10, 2013, revealed "...Skin Assessment...Buttocks red...Braden Scale Score 18 (18 or less are considered to be at risk of developing pressure ulcers)." Medical record review of a nursing note dated September 14, 2013, revealed "...Buttocks...Optifoam to stage II..." Medical record review of a nursing note dated September 15, 2013, revealed "...Stage II on buttocks/coccyx cleaned (with) wound cleanser, pat dry, applied new duoderm (and) hydrogel to wound..." Medical record review of physician's orders dated August 29, 2013, revealed "...Multivitamin...1 tablet...oral once a day..." Medical record review of physician's orders dated September 6, 2013, revealed "...Nutritionist eval (evaluation)-TF (tube feeding) recommendations..." Medical record review of Nutrition Progress Notes dated September 7, 2013, revealed "...Rec (recommend) use of Jevity 1.2 (at) goal rate of 75 ml (milliliters)/hr (hour)...will follow and monitor progress..."	F 314		

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F 314	Continued From page 12 Medical record review of Nutrition Progress Notes dated September 16, 2013, revealed "...Chart, labs reviewed. Pt. (patient) tolerating TF well..." Medical record review of a nursing note dated September 17, 2013, revealed "...(dressing) on coccyx (and buttocks (changed)..." Medical record review of physician's orders dated September 17, 2013, revealed "...D/C (discharge) to SNF (skilled nursing facility)...(stage) II (buttocks) per facility protocol..." Review of facility policy, Pressure Ulcer Prevention, revealed "...The admission assessment and daily assessment should include...a complete skin assessment. If the patient is identified as at risk on the Braden Scale (18 or lower), the nurse will make the physician aware of the risk and utilize skin care protocols...weekly wound measurements will be completed on patients with existing wounds and documented. When this is completed, the following will be documented for any wound assessment location, stage of ulcer, size/depth, length and width of pressure ulcer, condition of surrounding skin, presence of tracts or undermining and ulcer bed appearance...Implement skin care orders as appropriate." Review of facility protocol for pressure ulcers revealed "...Stage II...Needs MD order...Measure: Wound Area Dry to scant drainage Apply...Hydrogel Gel cover: Exuderm...Change every 3-5 days and at least weekly...Moderate to heavy drainage Apply: Maxorb...cover: Optifoam Adhesive...Change every 3-5 days and at least weekly...Obtain nutritional consult..."	F 314		

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F 314	Continued From page 13 Interview with the Director of Nursing (DON), on November 13, 2013, at 3:30 p.m., in the conference room confirmed no orders had been obtained for the treatment of the pressure ulcer and no complete assessment had been completed on the pressure ulcer. Interview with the DON on November 14, 2013, at 12:50 p.m., in the hall confirmed the Certified Nursing Assistants (CNA's) apply barrier cream to bedbound or incontinent residents. Interview with Registered Nurse (RN) #1 on November 14, 2013, at 1:20 p.m., by telephone confirmed the buttocks were red and blanchable on September 10, 2013. Continued interview with RN #1 confirmed the resident only had one pressure ulcer at the top of the buttocks. Resident #13 was admitted to the facility on September 6, 2013, with diagnoses including diabetes, Hypertension, Autoimmune Idiopathic Immune-Mediated Thrombocytopenia, Pulmonary Contusion, Status Post Motor Vehicle Accident, and Multiple Fractures. The resident was discharged on September 29, 2013. Medical record review of the skin assessment on the nursing note dated September 11, 2013, revealed "...2nd stage area (Stage II pressure ulcer noted...(no documentation of the assessment of the Stage II pressure ulcer)." Medical record review of nurse's notes from September 12, 2013 through September 14, 2013, revealed skin assessment of buttocks was within normal limits, or no skin assessment completed.	F 314		

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F 314	Continued From page 14 Medical record review of a physician's order dated September 15, 2013, revealed "...Sore/reddened area on bottom - c/w (clean with) EPC (barrier) cream..." Medical record review of a nursing note dated September 15, 2013, revealed "...buttocks red - barrier cream..." Medical record review of a physician's order dated September 18, 2013 revealed "...protocol to left buttock..." Medical record review of the nursing note dated September 19, 2013, revealed, "...Optifoam D/I (dry/intact)..." Medical record review of a nurse's note dated September 24, 2013, revealed "...Stage II Bilateral Buttocks, Optifoam D/I...(no assessment of the Stage II pressure ulcer on the bilateral buttocks)." Medical record review of a physician's order dated September 27, 2013, revealed "... Apply 4x4 Exuderm to open areas, Q (change) every 72 hours and prn (as needed) after BM (bowel movement)." Medical record review of a nurse's note dated September 27, 2013, revealed "...Exuderm...4x4 applied to (bilateral) buttocks open areas, ST. (stage) II (after) cleansing with wound cleanser and patted dry..." Medical record review of a nutrition progress note dated September 27, 2013, revealed "...Reports fair appetite...intake 50-100% overall... will add	F 314		

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F 314	Continued From page 15 ensure to trays...(sixteen days after Stage II pressure ulcer noted)." Interview with Director of Nursing on November 14, 2013, at 12:50 p.m., in the conference room confirmed a complete assessment of the pressure ulcer had not been completed and a nutritional assessment had not been completed timely. Resident #136 was admitted to the facility on October 31, 2013, with diagnoses including Acute Respiratory Failure, Exacerbation of Chronic Obstructive Pulmonary Disease, with history of Coronary Artery Disease with Coronary Artery Bypass Grafting, Atrial Fibrillation, Peripheral Vascular Disease, Diabetes Mellitus, and Decubitus Ulcers. Medical record review of the admission orders dated October 31, 2013, revealed an order for Wound Care indicating the facility protocol to be implemented. Medical record review of the Physician's orders titled, Pressure Ulcer Treatment protocol, dated November 7, 2013, revealed, "Consult dietary for Nutritional Assessment with wound healing guidelines... Use heel and elbow protectors..." Medical record review of the facility Admission Routine record dated October 31, 2013, revealed the System Assessment documentation indicated the resident was admitted with swelling, wound, scar, rash, ecchymosis, drainage and poor turgor. Further review revealed the resident was admitted with 2 "ulcers/pink tissue" on the left buttock; 2 "ulcers/pink tissue" on the right buttock; and one "sacral wound 1cm (centimeter)	F 314		

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F 314	Continued From page 16 deep 1 ½ cm wide." Review of the record revealed the sacral wound had developed the presence of a tunnel. Continued review of the record revealed the wounds on the buttocks were not staged or measured, and the sacral wound was not staged and the length was not measured. Medical record review of the facility Admission Routine form dated October 31, 2013, revealed the resident scored a "12" on the Braden Scale. Medical record review of the nursing documentation dated November 14, 2013, revealed, "1100 changed dressing on sacrum. Sacral wound is 1 cm deep, 1 cm long, and 1 cm wide. The wound on the right buttocks is ½ cm wide and 1 cm long. The wound to the side of that one is 1 quarter of an inch wide and ½ cm long. The wound on the left buttocks is 1 1/2 cm long and 1 cm wide. The other wound on the left buttock is ½ cm wide and 1 cm long. The buttocks are excoriated 16 cm wide and 20 cm long..." Medical record review revealed no documentation of the evaluation or measurements of the wounds since admission (14 days). Observation of the dressing change for resident #186 on November 14, 2013, at 11:00 a.m., revealed the resident continued to have 5 wounds to the buttock and sacral area. Continued observation revealed the resident did not have elbow or heel protectors in use. Interview with Registered Nurse (RN) #2, (the nurse who changed the dressing and documented) on November 14, 2013, at 2:48	F 314		

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F 314	Continued From page 17 p.m., confirmed the wound on the sacrum was a stage III and the wounds on the buttocks were a stage II. Interview with Certified Nursing Assistant (CNA #1) on November 14, 2013, at 11:35 a.m., in the hallway confirmed the resident did not have heel or elbow protectors in use. Interview with the Director of Nursing on November 14, 2013, at 12:31 p.m., at the hallway charting area confirmed the facility had failed to measure and assess wounds on admission and for the following 14 days; failed to notify dietary for a nutritional assessment; and failed to implement the use of heel and elbow protectors. Resident #185 was admitted to the facility on November 9, 2013, with diagnoses including Open Reduction and Internal Fixation of the Right Distal Femur, and Right Humeral Head Fracture. Medical record review of the nursing notes dated November 10, 2013, revealed the resident required extensive assistance of two or more persons for bed mobility and transfers. Medical record review revealed no documentation of the scoring of the Braden Scale for Predicting Pressure Ulcer Risk had been completed. Observation with Licensed Practical Nurse (LPN) #2 on November 14, 2013, at 3:45 p.m., revealed the resident lying on the bed. Continued observation revealed two staff members assisted the resident to turn to to the left side revealing a reddened area on the buttocks described as "blanchable."	F 314		

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F 314	Continued From page 18 Interview with the Director of Nursing and the Administrator on November 14, 2013, at 2:50 p.m., in the nursing station revealed the resident was at risk for the development of pressure ulcers and confirmed there was no scoring of the Braden Scale to indicate if the resident was at risk for the development of pressure ulcers.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356	**F356** 1. Daily nurse staffing was immediately posted as required. 2. The daily nurse staffing has been monitored daily since the November 12, 2013 noted deficiency. 3. 11 p.m. – 7 a.m. Charge Nurse and 7 a.m. – 3 p.m. Charge include the posting of daily nurse staffing as part of shift report to ensure compliance. 4. Random audits will be performed 3 times per week to ensure staffing is posted as required.	

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F 356	Continued From page 19 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure nurse staffing data was posted on a daily basis at the beginning of each shift. The findings included: Observation on November 12, 2013, at 8:20 a.m., during the initial tour revealed nurse staffing was posted at the nurse's station and the document was blank. Interview with Licensed Practical Nurse (LPN) #1, on November 12, 2013, at 8:30 a.m., in the nurse's station confirmed the facility failed to complete the nurse staffing data for November 12, 2013.	F 356		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F441** 1. Student was immediately re-educated to proper infection control procedures. The student was required to submit a written essay related to the importance of infection control instructor was immediately re-educated to proper infection control procedures. 2. A review of the census revealed no other residents were in isolation and no other residents were identified to be affected. 3. By December 15, 2013 all staff will be re-educated via classroom in service on proper infection control protocol. 4. 2 Staff will be randomly quizzed on a monthly basis beginning December 20, 2013 to assess their knowledge base related to infection control. Any staff not able to express proper protocol will be re-educated. Education will be provided on an annual basis in the computer based learning modules.	

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F 441	Continued From page 20 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and interview, the facility failed to clean equipment to prevent cross contamination for one of one isolation room. The findings included: Observation on November 12, 2013, at 10:15 a.m., revealed nursing student #1 exited the resident's room carrying a pulse oximeter, blood pressure cuff, and stethoscope on the clipboard in hand. Continued observation revealed the resident room was designated by sign and	F 441		

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F 441	Continued from page 21 equipment as a Contact Isolation room. Continued observation revealed the student nurse wiped the equipment with alcohol pads. Review of the facility policy, Cleaning and Disinfecting of Equipment, dated August 24, 2012, revealed "Procedure: ...#2. Follow manufacturer instructions for the type of cleaning and disinfecting solutions recommended, or use hospital approved solution." Interview with Director of Nursing (DON) in the medication room on November 13, 2013, at 8:45 a.m., confirmed the hospital approved solution for cleaning equipment taken into an isolation room was Cavi (bleach) wipes. Interview with the Registered Nurse (nursing instructor) in the hallway on November 13, 2013, at 9:19 a.m. confirmed the nursing instructor was not present when the nursing student exited the isolation room. Continued interview confirmed the student had failed to use the approved method of cleaning equipment according to facility policy	F 441		

PRINTED: 11/18/2013
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN4714	A. BUILDING: _____ B. WING _____	11/14/2013

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N 000	Initial Comments An annual Licensure survey was completed on November 12 - 14, 2013, at Tennova Heathcare-Tennova TCU. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela B Rogers RN/MSN	NHA	11/26/13

PRINTED: 11/19/2013
FORM APPROVED

Division of Health Care Facilities

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	TN4714	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	11/12/2013

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N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on November 13, 2013, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela B. Rogers, MSN	NHA	11/26/13

Tennova™ Healthcare

December 17, 2013

Ms. Karen L. Kirby, R.N.
Regional Administrator
ETRO Health Care Facilities
East Tennessee Region
5904 Lyons View Pike, Bldg. 1
Knoxville, TN 37917

RE: 44-5360

Dear Ms. Kirby:

Attached please find the addendum to the plan of correction originally submitted for the November 12-14, 2013 annual survey. I am submitting, as requested by Mr. Stuart Hurwitz, the documentation from Mr. Alan McCarthy dated July 25, 2012 which serves to clarify the deficiency cited for K029.

Thank you for your attention to this matter.

Sincerely,

Pamela B. Rogers

Pamela B. Rogers, Administrator

Enclosures

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445360	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TENNOVA HEALTH CARE-TENNOVA TCU	900 EAST OAK HILL AVENUE KNOXVILLE, TN 37917

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 9.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined hazardous area's one hour fire rated construction is maintained. The findings include: Observation and interview with the Maintenance Department representative, on November 13, 2013 at 9:35 p.m. confirmed a flexible combustible duct penetrated the soiled linen room's 1-hour rated wall and the penetration was not protected with a fire damper and rigid metal ductwork. This finding was verified by the Maintenance department Representative and acknowledged by the Director of Nursing during the exit conference on November 13, 2013.	K 029	**K029** 1. No residents were found to have been affected by the deficient practice. 2. No residents were found to have been affected by the deficient practice. 3. The Maintenance Department will have replaced the flexible combustible duct which penetrates the soiled linen room's 1 hour fire rated wall with a fire damper and rigid metal ductwork by December 20, 2013. 4. The Maintenance Department will make environmental rounds on an annual basis to identify any other areas which may be out of compliance and corrective action will be implemented. The rounds will be documented and maintained in the Maintenance Department. **December 27, 2013 Addendum:** **Communication with Mr. Stuart Hurwitz on November 16, 2013 revealed the following:** **"After closer review, I see the room we looked in is shown as only a smoke partition wall, therefore no fire dampers are required."** **The documentation which Mr. Hurwitz reviewed is attached.** Pamela B. Rogers 12/27/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela B. Rogers LPN/MSN	NHA	11/26/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Tennova TCU survey deficiency

Stuart Hurwitz [Stuart.Hurwitz@tn.gov]

Sent: Friday, December 06, 2013 12:09 PM
To: Rogers, Pam E
Cc: Karen Kirby [Karen.Kirby@tn.gov]

Pam,

I am responding to your email to Karen Kirby regarding the non-dampered duct which penetrated the soiled linen room's 1-hour rated wall in the Transitional care unit.
At the time of the survey, the wall appeared to be a typical 1-hour rated wall which would have required a fire damper.
Following the Survey, Leonard Vaugn had contacted me and explained that the wall was no longer a fire rated wall, just a smoke partition.

To address the deficiency K29of Correction (POC, please include the explanation from Mr. Vaugn and include the portion of the building drawing that confirms the wall as being a smoke partition. That will be sufficient for me to clear that deficiency.

Please feel free to call if you have any further questions.

Thank you,

Stuart Hurwitz – Fire Safety Specialist 2
5904 Lyons View Pike, Bldg 1
Knoxville, Tn 37919
(865) 588-5656 ext. **1044 ← NEW EXTENSION**

12072

RECEIVED
JUL 30 2012

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
710 HART LANE, 1ST FLOOR
NASHVILLE, TENNESSEE 37243
TELEPHONE (615) 741-6998
FAX (615) 253-1868

July 25, 2012

Mr. W. Robert Lundin, AIA
George Armour Ewart
404 Bearden Park Circle
Knoxville, TN. 37919

RE: Tennova – Physicians Medical Center-New soiled holding, Dictation room, New medicine prep room

Dear Mr. Lundin:

This office received your plan(s) for the above referenced project for review and approval. Since the renovation does not require full architectural submittal, this "We Concur" letter and stamp will serve as full documentation for approval. However, this letter does not relieve the owner, architects, sprinkler contractors or any other subcontractors from legal and/or regulatory responsibilities associated with the documents submitted for review.

If you need any further assistance please feel free to contact our office at (615) 253-4805.

Sincerely,

Alan M'Carthy

Alan M'Carthy
Facilities Construction Specialist III
Plans Review Section
Alan.mccarthy@tn.gov

Cc: Regional Administrator

ARCHITECT
EORGE ARMOUR
WART

RECEIVED
JUN 27 2012
HCF
PLANS REVIEW

26 June 2012

Tennessee Department of Health
710 Hart Lane, First Floor
Nashville, TN 37243

RE: Tennova – Physicians Regional Medical Center – TCU – 3rd Floor A-Wing
GAEA Project No. 12072

To Whom It May Concern:

We ask that the attached (2 sets) drawings to be reviewed for a concurrence letter for the proposed modifications to the existing facility located on 900 East Oak Hill Ave, TN 37917. The proposed modifications to the existing spaces consist of relocating a door in the Nourishment Room, creating a new Soiled Holding in an existing toilet, creating a Dictation Room in the existing Medicine Prep Room, and creating a new Medicine Prep Room in the existing Soiled Utility Room. We have included a check for $100.00 for the review fee.

If you have any questions or comments, please feel free to contact me.

Respectfully,
George Armour Ewart, Architect

W. Robert Bindin, AIA

hese plans and a set of
pecifications are required
o be kept at the job site
TENNESSEE DEPARTMENT OF HEALTH

We concur with the contents of this letter. The following actions are needed to expedite this project:

_____ Submit stamped plans and specs

_____ Submit aggends, c.o., or revised plans

_____ Submit sprinkler shop drawings

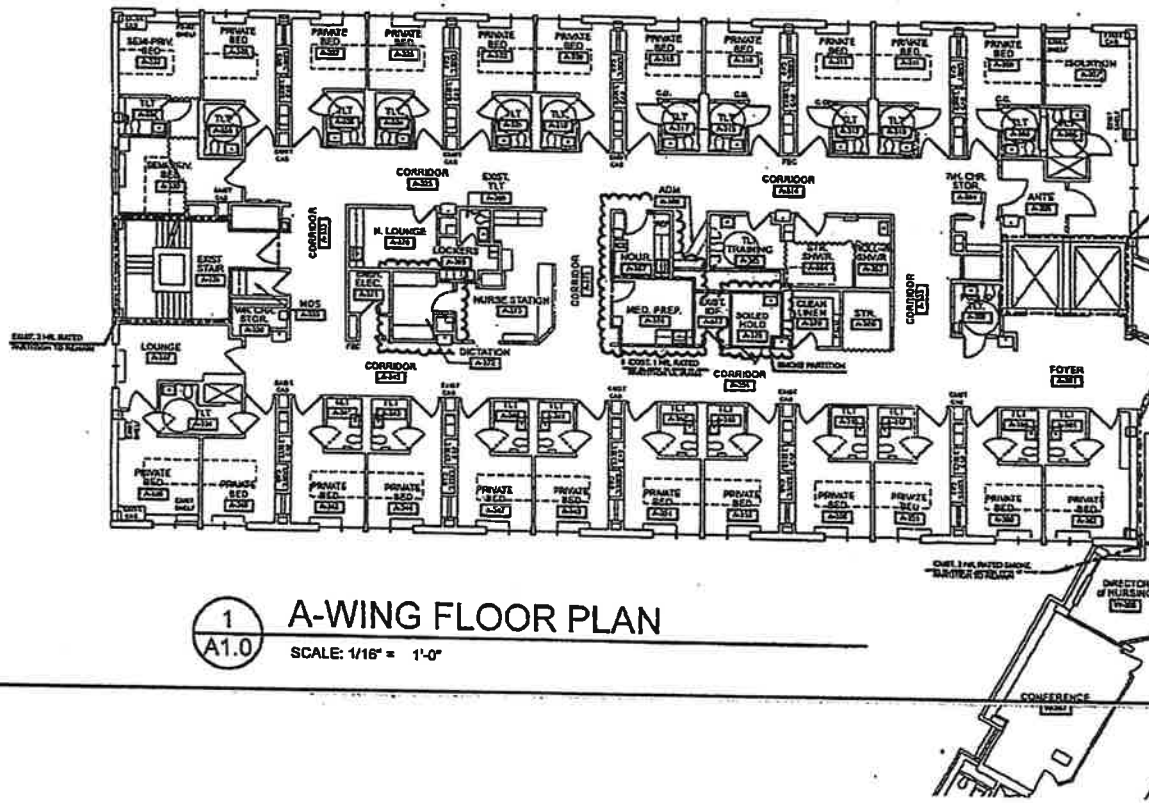
__✓__ other (see below)

_____ No futher action required.

Signed Title Date 7/25/12

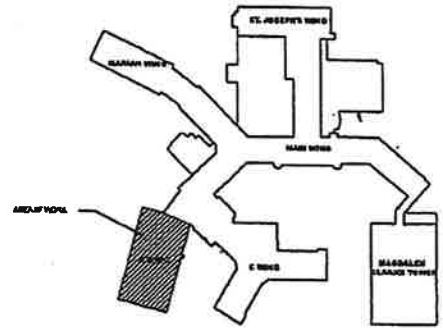
Coordinate Inspection with E&T TN. Regional Office.

4 Bearden Park Circle
oxville, TN 37919
one 865.602.7771
x 865.602.7742
ww.georgeewart.com



1 / A1.0 A-WING FLOOR PLAN

SCALE: 1/16" = 1'-0"



KEY PLAN - ST. MARY'S LEVEL 3

SCALE: N.T.S

ARCHITECT
GEORGE ARMOUR EWART
404 Bearden Park Circle
Knoxville, TN 37919
865-602-7771
Fax 865.602.7742
www.geor@ewart.com

office

These plans and a set of specifications are required to be kept at the job site

TENNESSEE DEPARTMENT OF HEALTH

RECEIVED
JUN 27 2012
HCF
PLANS REVIEW

minor renovation

PHYSICIANS REGIONAL MEDICAL CENTER

TRANSITIONAL CARE UNIT - ROOM CHANGES

KNOXVILLE, TN

DATE: 26 JUNE 2012

PROJECT NO.: 12072

A1.0

COPY-
SUPPLEMENTAL-1

Tennova Healthcare Nursing Home
CN1408-034

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

August 27, 2014

Melanie B. Burgess
Vice President of Development
Tennova Healthcare
930 Emerald Avenue, POB Suite 813
Knoxville, TN 37917

RE: Certificate of Need Application CN1408-034
Tennova Healthcare-Nursing Home

Dear Ms. Burgess:

This will acknowledge our August 13, 2014 receipt of your application for a Certificate of Need for the relocation of 25 nursing home beds located within Physicians Regional Medical Center located at 900 E. Oak Hill Avenue, Knoxville (Knox County), TN 37917 to an unaddressed site located consisting of 110 acres located at the intersection of Middlebrook and Old Weisgarber Road, across from Dowell Springs Boulevard, Knoxville, TN. The nursing home beds are planned to be located in a unit that will be constructed as part of the replacement and relocation of Physicians Regional Medical Center which is filing a separate Certificate of Need.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Friday, August 29, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Applicant Profile, Item 1**

   Please provide the proposed address rather than the current address of the applicant and resubmit a replacement page.

   The revised Applicant Profile is attached as attachment 1.

2. **Applicant Profile, Item 4**

   Please provide documentation from the Tennessee Secretary of State's web-site that the applicant is currently an active corporation. The web-site address is:
   https://tnbear.tn.gov/Ecommerce/FilingDetail.aspx?CN=144237204094069140106033033030121027092089000220

Documentation from the Tennessee Secretary of State's web-site is attached as attachment 2.

3. **Applicant Profile, Item 5, Management/Operating Entity**

Please provide the ownership structure of the Management/Operating Entity Community Health Systems Professional Services.

Community Health Systems Professional Services Corporation is wholly owned by CHS/Community Health Systems, Inc., which is wholly owned by Community Health Systems, Inc.

4. **Applicant Profile, Item 6, Legal Interest in Site**

The Real Estate Purchase Agreement for a 107+ parcel of land is noted. However, please provide documentation of the applicant's interest in the site. Please provide documentation that Oak Leaf Capital Partners, LLC is an agent of the applicant.

Documentation assigning the agreement from Oak Leaf Capital Partners, LLC to Metro Knoxville HMA, LLC is attached as attachment 4.

5. **Applicant Profile, Item 8, Purpose of Review**

Please also check "H. change of location" and resubmit page 3.

An updated page 3 is attached as attachment 5.

6. **Section A, Applicant Profile, Item 13**

The applicant's contractual relationships with BlueCare, United Community Healthcare Plan and TennCare Select are noted. However, new TennCare contracts will take effect January 1, 2015 with full statewide implementation for AmeriGroup, BlueCare Tennessee and United Healthcare. Please indicate if the applicant intends to contract with AmeriGroup. If so, what stage of contract discussions is the applicant involved with AmeriGroup?

The applicant does intend to contract with AmeriGroup and is currently in active negotiations to finalize those contracts.

7. **Section B. I. Project Description**

It is noted PRMC is a Marshall-Steele Premier Site for Joint Replacements. Please describe and discuss this designation. Is PRMC the only skilled nursing unit with this designation in the service area?

PRMC was deemed a Premier Site by the Marshall Steele Performance Enhancement Program in July, 2014. Only nine facilities nationwide have earned this distinction. The three closest programs are in Florida, Texas and Illinois.

Programs are chosen based on excellence in program organization and performance outcomes, including:
- Quality
- Patient/Family Empowerment
- Outcomes
- Surgical Experience and Expertise
- Cost Effectiveness
- Staff Specialization
- Continuous Improvement

It is noted the applicant is also a Blue Cross Blue Shield Distinction Center for hip and knee replacements. Please describe the Blue Cross Blue Shield Distinction Center program and two types of distinctions.

The Blue Distinction Center program evaluates hospitals on their ability to deliver high quality and safe specialty care based on criteria that directly impact patient results, for example surgical team expertise and a history of better outcomes for patients. Blue Distinction Center + designation not only indicates that the Blue Distinction Center quality criteria have been met, but also that the hospital has gone a step further by achieving benchmarks relative to how efficiently the high quality care is delivered.

Please complete the following table using the Directory of Blue Cross BlueShield Providers located at
http://www.bcbs.com/why-bcbs/blue-distinction/blue-distinction-centers-knee-hip-replacement/bluedistinctionkneehip.pdf

Hospital name	City	Designated Blue Distinction Center+ for hip and knee replacements (Y or N)	Designated Blue Distinction for hip and knee replacements Center (Y or N)
Fort Sanders Medical Center	Knoxville	Y	N
Parkwest Medical Center	Knoxville	Y	N
Tennova Healthcare Physicians Reg Med Ctr.	Knoxville	Y	N
University of Tennessee Medical Center	Knoxville	Y	N

8. **Section B. II. D. (Project Description)**

The applicant states the baseline costs to replace and/or upgrade the current 84 year old facility is estimated at $80 million. However, please provide documentation that supports this estimate.

The $80 million dollar estimate pertains simply to upgrading building infrastructure, such as electrical, boilers, chillers, and air handlers. The estimate was developed by the hospital's experienced facility engineering staff, and is attached as attachment 8. The facility engineering estimate, which is attached, only replaces the needed infrastructure (boilers, chillers, electrical, and air handlers), as well as to correct items that are out of code in the operating rooms, nursing and treatment areas. These items do not meet code because the code has changed so many times since the buildings were constructed.

The attached estimate totals over $92 million, but was reduced for the purposes of the application in order to be conservative. Any other upgrades, including paint, flooring, and other renovations that would be visible and helpful to the public, would be in addition to these costs.

9. **Section B, Project Description, Item IV (Floor Plan)**

The floor plans included in the application are not adequate to provide the Agency a clear understanding of what the applicant is proposing. Please provide larger, more detailed images with legible room labels of your project.

Updated floor plans are attached as attachment 9.

10. **Section C. NEED. (Specific Criteria: Construction, Renovation...)**

Please also respond to the construction and renovation criteria as it pertains to this 25 nursing bed relocation, not just to the hospital relocation.

The construction and renovation criteria for the relocation of existing healthcare services are:

(a) The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

As an important part of the overall continuum of care for patients of PRMC, hospital leadership believes it is important to keep the skilled nursing beds co-located with the hospital. Therefore, the primary answer to the criteria for location is that if the hospital relocates, the skilled nursing beds need to relocate along with the hospital. Considering the stand-alone options for the skilled nursing unit, however, there are two alternatives to relocating to the replacement hospital facility:

- Stay at the existing campus and renovate the space. If the replacement hospital application is approved, leaving the skilled nursing unit at the existing site defeats the purpose of the unit, which is to provide:
  a.) Post-acute services following an acute care stay, with the opportunity for medical management to be provided by the same physicians who oversaw the acute stay, or
  b.) Post-surgical patients who have had orthopedic surgery and need skilled nursing care and therapy during the recovery period.

In addition to not fully meeting the needs of the patients, renovating the space is cost-prohibitive. Renovation of the skilled nursing unit within the existing facility is particularly expensive because:

a.) Bathrooms are currently too small to accommodate any form of equipment (wheelchairs, walkers) and most do not contain a shower. Expanding the bathroom and adding a shower in each room is an expensive renovation.

b.) A significant renovation of that kind would require that the entire space be brought up to meet current code requirements. The unit is located in a building constructed in 1966, in which many elements, while not inherently unsafe, do not meet current code requirements. For example, current codes require that there be sufficient space between the ceiling of a patient care unit and the floor of the space above it such that air exchanges, data and communications lines, sprinklers, etc. can be housed between the ceiling and the floor above. The spaces between the ceilings and the floors above in the existing hospital are inadequate to meet this requirement, and there is no reasonable way to renovate that would allow the requirement to be met, short of gutting the entire unit. Any significant renovation or addition to the existing facility would require that these items be corrected, which adds exponentially to the cost of improvements.

- Build a free-standing skilled nursing facility. While a freestanding skilled nursing facility could be built, the advantages in terms of both construction costs and operational efficiency of having the unit located in the hospital are significant. The cost of site preparation, general conditions, and land purchase/facility leasing are shared between the hospital project and the skilled nursing unit, rather than the skilled nursing beds bearing the entire cost of a building project.

(b) The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

There is an acceptable existing and projected future demand for the skilled nursing unit. While volumes have declined somewhat over the past several years, primarily as a result of the facility challenges that exist in the unit, it was at 74.6% of capacity in 2012 and 75.9% of capacity in 2013. Recognizing that senior adult populations are projected to grow at a more rapid rate than the rest of the population - 3.4% per year over the next five years - it is reasonable to assume that there is a continued need for the skilled nursing services being provided by PRMC's unit. A chart showing historic and project utilization is attached as attachment 10, demonstrating ongoing need for the skilled nursing unit.

11. Section C. NEED. Question 5

The 2012 utilization table on page 30 is noted. However, please provide the same table for 2010 and 2011.

Utilization tables for 2010 and 2011 are attached as attachment 11.a. A revised table for 2012 has also been included in attachment 11.a, as errors were found in the original chart that was submitted.

The two tables on top of page 31 appear to have errors. Please revise and resubmit. Please add a column to the chart on the top of page 31 that shows the percent % from 2010 to 2012 in patient days.

A revised chart is attached as attachment 11.b.

12. **Section C. NEED. Question 6 (Applicant Utilization)**

The table on page 32 is noted. Please add a row to the chart to show occupancy and resubmit a replacement page.

A revised chart is attached as attachment 12.

13. **Section C. Economic Feasibility Item 1 (Project Cost Chart)**

The architect's letter is noted. However, please provide documentation from a licensed architect or construction professional that includes the following:

1) his/her estimate of the cost to construct the project to provide a physical environment, according to applicable federal, state and local construction codes, standards, specifications, and requirements and

2) attesting that the physical environment will conform to applicable federal standards, manufacturer's specifications and licensing agencies' requirements including the new 2010 AIA Guidelines for Design and Construction of Hospital and Health Care Facilities.

A letter from the architect is attached as attachment 13.

Your response is noted. Please breakout the listing of moveable medical equipment in the Project Costs Chart which will cost more than $50,000.

There is no piece of moveable medical equipment proposed that will cost $50,000 or more.

14. **Section C, Economic Feasibility, Item 2 and Item 10**

The letter from the applicant's Chief Financial Officer is noted. However, please resubmit the letter specifying the proposed project will be funded through cash reserves.

The letter has been updated and is attached as attachment 14.

It is noted the applicant plans to fund the proposed $6,454,796 project with cash reserves. However, Community Health Systems Consolidated Balance Sheet ending December 31, 2013 reflects $373,403,000 in cash and cash equivalents, a total of $3,747,963,000 in current assets and $2,457,483,000 in current liabilities resulting in a current ratio of 1.52:1. Please discuss the availability of cash to fund operations of Community Health Systems while 81.2% of available cash will be devoted to another proposed $303,545,204 Tennova Project, Physician's Regional Medical Center, CN1408-033, for the relocation and replacement of Physician Regional Medical Center.

CHS/Community Health Systems, Inc. plans to use cash on hand to fund the costs of the project and notes that the costs would be incurred over the life of the project and therefore excess cash flow from operations would be available to replenish cash on hand. In the event that cash on hand does not cover the entire cost of the project, CHS/Community Health Systems would have $700,000,000 available under its Revolving Line of Credit. The revolver is liquid in that funds can be made available on the same day, if necessary.

Please discuss how the recent Medicare settlement of $98,000,000 to resolve allegations CHS overbilled Medicare and Medicaid will impact the financial viability and cash flow of CHS and the funding of this project.

The settlement payment has been fully funded and will have no impact on the ability to provide capital resources for the project.

It is reported Community Health Services recently was the victim in the cyber theft of personal patient data belonging to 4.5 million patients. Please clarify if this theft will have a material adverse effect on CHS financial results.

CHS/Community Health Systems, Inc. carries cyber/privacy liability insurance and does not believe this incident will have a material adverse effect on its business or financial results.

15. Section C, Economic Feasibility, Item 3

The costs per square foot of construction compared to similar projects recently approved are noted. What year is the applicant basing the comparison?

The comparison came directly from the Health Services and Development Agency, and is for 2013.

16. **Section C. (Economic Feasibility) Question 4 (Historical Data Chart)**

Please clarify the reason contractual adjustments decreased from $6,156,568 in 2011 to $4,536,146 in 2013.

Effective October 1, 2012, CMS recalibrated its reimbursement schedule for skilled nursing services, reducing payments for some therapy-based services, but increasing reimbursement for others. In addition, the skilled nursing unit and PRMC were under different ownership in 2011 versus 2013, which created a change in managed care rates for those patients with commercial insurance.

Please clarify the reason there are no taxes allocated in the historical data chart.

According to our accounting methodologies, taxes are not allocated back to any single department within the same facility. As long as that department is owned by the same legal entity as the hospital, which the skilled nursing unit is, taxes are only reflected in financial statements for the entire hospital.

Why are there no management fees allocated for years 2011-2013 in the Historical Data Chart?

According to our accounting methodologies, management fees, which in our case are actually corporate cost allocations, are not allocated back to any single department within the same facility. As long as that department is owned by the same legal entity as the hospital, which the skilled nursing unit is, management fees/corporate allocations are only reflected in financial statements for the entire hospital.

Please clarify the reason "other expenses" increased from $35,093 in 2011 to $1,525,777 in 2013.

Between 2011 and 2012, two primary support services were outsourced, shifting those costs from salaries and supplies into "other expenses." Those support services are housekeeping and dietary.

Why was there no ancillaries' expense in 2011? What is included in the ancillaries' expense?

Ancillary expense is the cost of providing "ancillary" services to patients within the skilled nursing unit, such as lab work and diagnostic imaging. In 2011, the skilled nursing unit and PRMC were part of Mercy Health Partners, and the accounting procedures in place at that time did not allocate the cost of performing ancillary services for skilled nursing patients back to the department. Following the change in ownership to Health Management

Associates, that accounting practice changed, and those services were charged back as expenses to the unit.

17. Section C. (Economic Feasibility) Question 4 (Projected Data Chart)

Please specify the utilization data (unit of measure).

The unit of measure is admissions. An updated Projected Data Chart is attached as attachment 17.

Why are there no management fees in the Projected Data Chart. If needed, please include management fees in the Projected Data Chart and resubmit.

While management services are provided by Community Health Systems Professional Services Corporation, management fees are accounted for "below the line," and will not be reflected as an expense to the hospital in future years.

18. Section C. (Economic Feasibility) Question 9

Please verify the amount calculated of $5,479,783 that represents 51% Medicare/Managed Care. It appears the total is $5,437,139.

Agreed. The correct amount is $5,437,139.

The participation in state and federal programs is noted. Please clarify if the Medicare/Managed Care and TennCare/Medicaid payor mix will change as a result of the proposed relocation. If so, by what percentage?

No change in payor mix is anticipated as a result of the proposed relocation.

Also, please verify the Self Pay amount of $223,882. It appears to be $213,222.

Agreed. The correct amount is $213,222.

19. Section C. (Economic Feasibility) Question 11

If this project is approved it will take approximately 3.3 years to relocate to the new site. The applicant could relocate to Turkey Creek or North Knoxville Medical Center that experienced occupancy rates of 45.7% and 37.9% in 2012 and has capacity. Has the applicant considered relocating the 25 bed skilled nursing unit to either Turkey Creek or North Knoxville Medical Center? Please discuss.

The option of moving the skilled nursing unit to either North Knxoville Medical Center or Turkey Creek Medical Center has been considered. In spite of the relatively low current occupancy numbers for Turkey Creek

Medical Center and North Knoxville Medical Center, both hospitals are experiencing growth and the expansion of services. North Knoxville Medical Center will soon be housing Select Specialty Hospital, as well as adding cardiac catheterization services, following the approval of the certificate of need application last year. With its complement of surgical services, particularly the growth of bariatric surgery services, Turkey Creek has high peaks in occupancy during certain days of the week which would make it difficult to move the 25 skilled nursing beds there. More importantly, however, the skilled nursing unit provides a natural post-acute setting for PRMC's high volume of post-surgical orthopedic patients and benefits from the physician referral patterns that have already been established for the unit.

If Physician's Regional Medical Center's application, CN1408-033 for a replacement hospital is not approved, what are the plans for the 25 bed skilled nursing unit?

If the replacement hospital application is not approved, the skilled nursing unit will remain in its current location.

20. Section C. (Contribution to Orderly Development) Question 2.

The applicant states the proposed project will have no impact on existing providers. Since the applicant is moving 9 miles toward a higher growth area how can this project not have an impact on existing providers?

The skilled nursing unit is primarily a resource for patients who need additional care following an acute care hospital stay, or for patients who require more medical supervision than a freestanding or more therapy-centered nursing home can provide. Referrals into the skilled nursing facility are driven by physicians who admit patients into PRMC or its sister facilities. It is not expected that those referral patterns will change simply due to relocating the unit.

Please provide an overview of Orthopedic Physicians Practices located near the current site and near the proposed site.

There are no orthopedic physician practice sites located near the current site, although orthopedic surgeons do provide coverage for inpatients at PRMC. Knoxville Orthopaedic Clinic has an office in the Dowell Springs medical complex, which is across Middlebrook Pike from the proposed site.

21.Section C. (Contribution to Orderly Development) Question 3. (Current and Proposed Staffing)

Please provide the current direct patient care staffing level of the 25 bed skilled nursing unit.

The current direct patient care staffing level of the nursing unit is:

Registered Nurses –	8.0 FTE

Licensed Practical Nurses –	5.0 FTE
Certified Nursing Assistants –	7.0 FTE
Total	20.0 FTE

22. Section C. (Contribution to Orderly Development) Question 7 (b.) and 7 (d.)

The Tennessee Department of Health license for Tennova Healthcare-Physicians Regional Medical Center is out of date. Please provide a copy of a current license.

The current license is attached as attachment 22.

Please clarify why the hospital is Joint Commission accredited, but the 25 bed skilled nursing unit is not.

The Joint Commission accreditation process for long-term care facilities, including skilled nursing units, is a separate and specific accreditation process, outside the process for the hospital. Very few long-term care facilities choose to participate in the Joint Commission process. The unit is surveyed annually by the State.

23. Section C. (Contribution to Orderly Development) Question 8

The applicant mentions a civil judgment involving North Knoxville Medical Center. Please provide a brief overview. In your response, please clarify if this judgment will impact the applicant's ability to contract with government payers in the future.

The civil judgment is against North Knoxville Medical Center's former owner, Catholic Health Partners. Because the current ownership of the hospital is not privy to the details of the case, an overview cannot be provided. As a civil judgment that is being appealed, there is no expectation that there will be any impact on the applicant's ability to contract with government payors in the future.

24. Project Completion Chart

The applicant projects the final project report form to be filed in June 2018. Does the applicant plan to request an extension past a 3 year certificate of need time frame?

The applicant will be requesting a four year time frame to complete the project if approved.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed

void." In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is October 21, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

PME

Enclosure

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

List of Attachments

Attachment 1	Replacement page – Applicant Profile
Attachment 2	Corporate Information from TN Secretary of State
Attachment 4	Assignment of Real Estate Purchase and Sale Agreement
Attachment 5	Page 3, Updated
Attachment 8	Cost Estimate by PRMC Facility Engineering
Attachment 9	Updated Floor Plans
Attachment 10	Historic and Projected Utilization Chart
Attachment 11.a	Utilization Tables – 2010 - 2012
Attachment 11.b	Revised Service Area Skilled Nursing Unit Chart
Attachment 12	Revised Historic and Projected Utilization Chart
Attachment 13	Architect's Letter
Attachment 14	Updated CFO Letter
Attachment 17	Updated Projected Data Chart
Attachment 22	Skilled Nursing Unit License

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Attachment 8

Infrastructure Replacement/Improvement Costs - Per Facility Engineering

	UOM	Qty		Dollars Per	Extended Cost
Central Electrical Plant	Ea	1	$	3,590,400	3,590,400
Air handlers	Ea	118	$	48,000	5,664,000
Chillers	Tons	3,800	$	1,500	5,700,000
Boilers	Ea	3	$	250,000	750,000
Upgrade units to code*	SF	383,113	$	200	76,622,600
					$ 92,327,000

*Only includes operating rooms, nursing units, and diagnostic & treatment areas

Attachment 10

PRMC Skilled Nursing Unit - Historic and Projected Utilization

Skilled Nursing	2011	2012	2013	2014 Annualized	2015	2016	2017	2018 - Project Year 1	2019 - Project Year 2
Admissions	810	771	730	687	697	708	718	742	767
Patient Days	6,810	6,767	6,930	6,958	6,935	7,039	7,145	7,383	7,630
ADC	18.7	18.5	19.0	19.1	19.0	19.3	19.6	20.2	20.9
Occupancy	74.6%	74.2%	75.9%	76.3%	76.0%	77.1%	78.3%	80.9%	83.6%

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Attachment 11.a

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS SUMMARY OF UTILIZATION CALENDAR YEAR 2010					
SKILLED NURSING UNIT	**Beds**	**Admissions**	**Patient Days**	**ADC**	**Occupancy Rate**
Physicians Regional Medical Center TCU	25	822	7,413	20.3	81.24%
Blount Memorial Transitional Care	76	1,186	26,292	72.0	94.78%
Claiborne County Nursing Home	100	236	30,089	82.4	82.44%
Fort Sanders Transitional Care	24	554	7,159	19.6	81.72%
Fort Sanders Sevier Nursing Home	54	140	16,635	45.6	84.40%
Tennova - LaFollette Health & Rehabilitation Ctr	98	331	34,109	93.4	95.36%
Total	377	3,269	121,697	333.4	88.44%

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS SUMMARY OF UTILIZATION CALENDAR YEAR 2011					
SKILLED NURSING UNIT	**Beds**	**Admissions**	**Patient Days**	**ADC**	**Occupancy Rate**
Physicians Regional Medical Center TCU	25	810	6,804	18.6	74.56%
Blount Memorial Transitional Care	76	1,186	25,509	69.9	91.96%
Claiborne County Nursing Home	100	208	32,529	89.1	89.12%
Fort Sanders Transitional Care	24	596	6,714	18.4	76.64%
Fort Sanders Sevier Nursing Home	54	133	15,593	42.7	79.11%
Tennova - LaFollette Health & Rehabilitation Ctr	98	321	33,397	91.5	93.37%
Total	377	3,254	120,546	330.3	87.60%

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS SUMMARY OF UTILIZATION CALENDAR YEAR 2012					
SKILLED NURSING UNIT	**Beds**	**Admissions**	**Patient Days**	**ADC**	**Occupancy Rate**
Physicians Regional Medical Center TCU	25	771	6,767	18.5	74.16%
Blount Memorial Transitional Care	76	1,252	25,213	69.1	90.90%
Claiborne County Nursing Home	100	220	32,745	89.7	89.70%
Fort Sanders Transitional Care	24	593	6,834	18.7	78.00%
Fort Sanders Sevier Nursing Home	54	120	16,556	45.4	84.00%
Tennova - LaFollette Health & Rehabilitation Ctr	98	342	29,742	81.5	83.15%
Total	377	3,298	117,857	322.90	85.65%

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Attachment 11.b

SERVICE AREA HOSPITAL BASED SKILLED NURSING UNITS
ADMISSION AND PATIENT DAY TREND
CALENDAR YEAR 2010 THROUGH 2012

SKILLED NURSING UNIT	*Admissions/Discharges*			*Patient Days*		
	2010	2011	2012	2010	2011	2012
Physicians Regional Med Center TCU	822	810	771	7,413	6,810	6,767
Blount Memorial Transitional Care	1,138	1,186	1,252	25,760	26,292	25,213
Claiborne County Nursing Home	191	208	220	29,801	31,886	32,745
Fort Sanders Transitional Care	554.00	596	593	7,159	6,662	6,834
Fort Sanders Sevier Nursing Home	140.00	133	120	16,635	15,598	16,556
LaFollette Health & Rehabiltation Ctr	342	321	342	29,742	29,419	29,742
Total	3,187	3,254	3,298	116,510	116,667	117,857

		Change - Admissons	Percent Change		Change - Patient Days	Percent Change
Physicians Regional Med Center TCU		(51)	-6.2%		(646)	-8.7%
Blount Memorial Transitional Care		114	10.0%		(547)	-2.1%
Claiborne County Nursing Home		29	15.2%		2,944	9.9%
Fort Sanders Transitional Care		39	596.0%		(325)	
Fort Sanders Sevier Nursing Home		(20)	133.0%		(79)	
LaFollette Health & Rehabilitation Ctr		-	0.0%		-	0.0%
Total	--	111	3.5%	--	1,347	39.6%

Attachment 12

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Attachment 13

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Thomas, Miller & Partners, PLLC
Architecture Interiors Planning Sustainable Design

5210 Maryland Way, Suite 200
Brentwood, Tennessee 37027-5065
615.377.9773
www.tmpartners.com

Marc Stephen Rowland REGISTERED ARCHITECT AGRICULTURE ARTS COMMERCE NO. 021347 STATE OF TENNESSEE 8-26-2014

Date August 26, 2014

To Ms. Melanie Burgess
Vice President of Development, Tennova Healthcare
930 East Emerald Avenue, POB 8th Floor
Knoxville, Tennessee 37919

Project Skilled Nursing Facility-TCU – Physicians Regional Medical Center
Knoxville, Tennessee
TMP No. A04614

Subject Proposed Cost and Applicable Code Information

Dear Ms. Burgess

I have reviewed the cost information for the referenced project. The probable construction cost is $5,895,000. Line items for equipment, contingency, and architectural/engineering fees bring the total probable project cost to $6,454,796. Having current experience with comparable projects, it is my professional opinion that these costs are reasonable and compare favorably with similar projects.

This project is being developed under the current codes and standards enforced by the State of Tennessee as follows:

2012	INTERNATIONAL BUILDING CODE (IBC)
2012	INTERNATIONAL MECHANICAL CODE
2012	INTERNATIONAL PLUMBING CODE
2012	INTERNATIONAL FUEL GAS CODE
2011	NATIONAL ELECTRIC CODE
2012	INTERNATIONAL ENERGY CONSERVATION CODE
2012	NFPA 101 LIFE SAFETY CODE
2002	NORTH CAROLINA ACCESSIBILITY CODE WITH 2004 AMENDMENTS
2010	ADA STANDARDS FOR ACCESSIBLE DESIGN
2010	FGI - GUIDELINES FOR DESIGN AND CONSTRUCTION OF HEALTH CARE FACILITIES
2008	ASHRAE HANDBOOK OF FUNDAMENTALS

Please let me know if any further information is required.

Sincerely,

Marc S. Rowland, AIA ACHA
Principal-in-Charge
Tennessee Certificate Number 21,347

Copy: A04614 gf

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Attachment 17

SUPPLEMENTAL- # 1
August 28, 2014
8:35am

Attachment 22

207

Tennova™ Healthcare

RECEIVED
AUG 29 2014
SUPPLEMENTAL

August 28, 2014

Mark Farber
Tennessee Health Services and Development Agency
Andrew Jackson Building
502 Deaderick Street, 9th floor
Nashville, TN 37243

Re: Additional Information re: 2nd Request for Supplemental Information, CN1408-034

Dear Mr. Farber:

This letter transmits additional information regarding our response to your request for supplemental information to our recent Certificate of Need application. The signed and notarized affidavit is also enclosed.

I am the contact person for this project. Please advise me of any additional information you may need. We appreciate your consideration of the responses submitted.

Sincerely,

Melanie B. Burgess
Vice President of Development

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Knox

NAME OF FACILITY: Metro Knoxville HMA, LLC, d/b/a Physicians Regional Medical Center

I, MELANIE B. BURGESS, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 29 day of August, 2014, witness my hand at office in the County of Knox, State of Tennessee.

NOTARY PUBLIC

My commission expires Sept. 11, 2017.

HF-0043

Revised 7/02

LINDA R. COOPER STATE OF TENNESSEE NOTARY PUBLIC KNOX COUNTY

SUPPLEMENTAL-#2

-Copy-

TENNOVA HEALTHCARE Nursing Home

CN1408-034

SUPPLEMENTAL #2
August 29, 2014
7:44 am

AUG 29 2014

AFFIDAVIT

STATE OF TENNESSEE

COUNTY OF Knox

NAME OF FACILITY: Metro Knoxville HMA, LLC, d/b/a Physicians Regional Medical Center

I, MELANIE B. BURGESS, after first being duly sworn, state under oath that I am the applicant named in this Certificate of Need application or the lawful agent thereof, that I have reviewed all of the supplemental information submitted herewith, and that it is true, accurate, and complete.

Melanie B Burgess VP
Signature/Title

Sworn to and subscribed before me, a Notary Public, this the 28 day of August, 2014, witness my hand at office in the County of Knox, State of Tennessee.

Linda R. Cooper
NOTARY PUBLIC

My commission expires Sept. 11, 2017.

HF-0043

Revised 7/02

LINDA R. COOPER
STATE OF TENNESSEE NOTARY PUBLIC
KNOX COUNTY

SUPPLEMENTAL #2
August 29, 2014
7:44 am

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building, 9th Floor
502 Deaderick Street, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-2364/Fax: 615-741-9884

August 28, 2014

Melanie B. Burgess
Vice President of Development
Tennova Healthcare
930 Emerald Avenue, POB Suite 813
Knoxville, TN 37917

RE: Certificate of Need Application CN1408-034
Tennova Healthcare-Nursing Home

Dear Ms. Burgess:

This will acknowledge our August 28, 2014 receipt of your supplemental response for an application for a Certificate of Need for the relocation of 25 nursing home beds located within Physicians Regional Medical Center located at 900 E. Oak Hill Avenue, Knoxville (Knox County), TN 37917 to an unaddressed site located consisting of 110 acres located at the intersection of Middlebrook and Old Weisgarber Road, across from Dowell Springs Boulevard, Knoxville, TN. The nursing home beds are planned to be located in a unit that will be constructed as part of the replacement and relocation of Physicians Regional Medical Center which is filing a separate Certificate of Need.

Several items were found which need clarification or additional discussion. Please review the list of questions below and address them as indicated. The questions have been keyed to the application form for your convenience. I should emphasize that an application cannot be deemed complete and the review cycle begun until all questions have been answered and furnished to this office.

Please submit responses in triplicate by 12:00 noon, Friday, August 29, 2014. If the supplemental information requested in this letter is not submitted by or before this time, then consideration of this application may be delayed into a later review cycle.

---

1. **Section C, Economic Feasibility, Item 2 and Item 10**

   The applicant notes a $700,000,000 Revolving Line of Credit is available in the event cash on hand does not cover the entire cost of the project. Please provide documentation from a lending institution that identifies the availability of a revolving line of credit that will cover project costs. Please also include the expected interest rate, term of the loan, and any anticipated restrictions or conditions.

   The requested documentation is attached as attachment 1.

2. **Section C. (Economic Feasibility) Question 4 (Projected Data Chart)**

   The applicant states methods of accounting have changed and management fees are accounted "below the line". Please clarify the term "below the line". Does this mean PRMC will be provided management services but will not be charged for those services? If so, where is this expense allocated?

   Under PRMC's current accounting methods, management fees are not considered an operating expense. The financial information in the Projected Data Chart reflects operating revenue, expense, and profit or loss from operations. The term "below the line" means that management fees are accounted for outside of hospital operations, or "below the line" on the financial statement reflecting profit or loss from hospital operations.

3. **Affidavit**

   A signed and notarized affidavit must be submitted with each filing of supplemental information. An affidavit was not included with the previous supplemental request. Please submit a completed affidavit for the first supplemental submission and one for this supplemental request.

   Our records indicate that an affidavit was submitted with the previous supplemental request, but two affidavits are included. One is for the first supplemental request and another for this supplement request.

In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." In accordance with Tennessee Code Annotated, §68-11-1607(c) (5), "...If an application is not deemed complete within sixty (60) days after written notification is given to the applicant by the agency staff that the application is deemed incomplete, the application shall be deemed void." **For this application the sixtieth (60th) day after written notification is October 21, 2014. If this application is not deemed complete by this date, the application will be deemed void.** Agency Rule 0720-10-.03(4) (d) (2) indicates that "Failure of the applicant to meet this deadline will result in the application being considered withdrawn and returned to the contact person. Re-submittal of the application must be accomplished in accordance with Rule 0720-10-.03 and requires an additional filing fee." Please note that supplemental information must be submitted timely for the application to be deemed complete prior to the beginning date of the review cycle which the applicant intends to enter, even if that time is less than the sixty (60) days allowed by the statute. The supplemental information must be submitted with the enclosed affidavit, which shall be executed and notarized; please attach the notarized affidavit to the supplemental information.

If all supplemental information is not received and the application officially deemed complete prior to the beginning of the next review cycle, then consideration of the application could be delayed into a later review cycle. The review cycle for each application shall begin on the first day of the month after the application has been deemed complete by the staff of the Health Services and Development Agency.

Any communication regarding projects under consideration by the Health Services and Development Agency shall be in accordance with T.C.A. ə 68-11-1607(d):

SUPPLEMENTAL #2
August 29, 2014
7:44 am

(1) No communications are permitted with the members of the agency once the Letter of Intent initiating the application process is filed with the agency. Communications between agency members and agency staff shall not be prohibited. Any communication received by an agency member from a person unrelated to the applicant or party opposing the application shall be reported to the Executive Director and a written summary of such communication shall be made part of the certificate of need file.

(2) All communications between the contact person or legal counsel for the applicant and the Executive Director or agency staff after an application is deemed complete and placed in the review cycle are prohibited unless submitted in writing or confirmed in writing and made part of the certificate of need application file. Communications for the purposes of clarification of facts and issues that may arise after an application has been deemed complete and initiated by the Executive Director or agency staff are not prohibited.

Should you have any questions or require additional information, please do not hesitate to contact this office.

Sincerely,

Phillip M. Earhart
Health Services Development Examiner

PME

Enclosure

List of Attachments

Attachment 1	Verification of Revolving Line of Credit

SUPPLEMENTAL #2
August 29, 2014
7:44 am

Attachment 1

EX-10.1 10 d663459dex101.htm EX-10.1

Exhibit 10.1

EXECUTION VERSION

THIRD AMENDMENT AND RESTATEMENT AGREEMENT dated as of January 27, 2014 (this "***Agreement***"), to the CREDIT AGREEMENT dated as of July 25, 2007, as amended and restated as of November 5, 2010 and February 2, 2012 (as amended, supplemented or otherwise modified prior to the date hereof, the "***Existing Credit Agreement***"), among CHS/COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation, COMMUNITY HEALTH SYSTEMS, INC., a Delaware corporation, the Subsidiary Guarantors listed on the signature pages hereto, the Lenders listed on the signature pages hereto and CREDIT SUISSE AG, as Administrative Agent and Collateral Agent.

PRELIMINARY STATEMENT

The Borrower has requested that the Existing Credit Agreement be amended and restated in the form attached hereto as Exhibit A (as so amended and restated, the "***Third Restated Credit Agreement***"), to provide for, among other things:

(a) the making of 2019 Term A Loans (defined below) to the Borrower on the Third Restatement Effective Date (as defined below), on the terms and subject to the conditions set forth herein and in the Third Restated Credit Agreement, in an aggregate principal amount of $1,000,000,000;

(b) the making of 2017 Term E Loans (defined below) to the Borrower on the Third Restatement Effective Date, on the terms and subject to the conditions set forth herein and in the Third Restated Credit Agreement, in an aggregate principal amount of $171,146,550.47;

(c) the making of 2021 Term D Loans (defined below) to the Borrower on the Third Restatement Effective Date, on the terms and subject to the conditions set forth herein and in the Third Restated Credit Agreement, in an aggregate principal amount of $2,925,000,000;

(d) the repayment in full of (i) all the Incremental Term Loans incurred on the First Incremental Term Loan Assumption Agreement Date (each as defined in the Existing Credit Agreement) outstanding on the Third Restatement Effective Date (the "***Incremental Term Loans***"); (ii) all the Non-Extended Term Loans (as defined in the Existing Credit Agreement) outstanding on the Third Restatement Effective Date; and (iii) all the Extended Term Loans (as defined in the Existing Credit Agreement) that are not converted into either 2021 Term D Loans or 2017 Term E Loans as described below;

(e) (i) the extension of the maturity of, and modification of the pricing terms with respect to, certain of the Extended Term Loans so that such Extended Term Loans shall be converted into 2021 Term D Loans with such converted

Extended Term Loans being treated with the 2021 Term D Loans made on the Third Restatement Effective Date as a single Class for all purposes under the Third Restated Credit Agreement; and (ii) the modification of the pricing terms with respect to, certain of the Extended Term Loans so that such Extended Term Loans shall be converted into 2017 Term E Loans with such converted Extended Term Loans being treated with the 2017 Term E Loans made on the Third Restatement Effective Date as a single Class for all purposes under the Third Restated Credit Agreement;

(f) the termination of all the Revolving Credit Commitments (as defined in the Existing Credit Agreement), the repayment in full of all outstanding Revolving Loans (as defined in the Existing Credit Agreement) and the establishment of replacement Revolving Credit Commitments under the Third Restated Credit Agreement in an aggregate principal amount of $1,000,000,000; and

(g) the modification of certain covenants and other provisions set forth in the Existing Credit Agreement.

The Borrower has requested that the persons set forth on Schedule I hereto (the "***2019 Term A Lenders***") commit to make 2019 Term A Loans to the Borrower on the Third Restatement Effective Date in an aggregate principal amount of $1,000,000,000 (the "***2019 Term A Loans***"; the commitment of each 2019 Term A Lender to provide its applicable portion of the 2019 Term A Loans, a "***2019 Term A Commitment***"). The 2019 Term A Lenders are willing to make the 2019 Term A Loans to the Borrower on the Third Restatement Effective Date on the terms set forth herein and in the Third Restated Credit Agreement and subject to the conditions set forth herein.

The Borrower has requested that the persons set forth on Schedule II hereto (the "***2017 Term E Lenders***") commit to make 2017 Term E Loans to the Borrower on the Third Restatement Effective Date in an aggregate principal amount of $171,146,550.47 (the "***2017 Term E Loans***"; the commitment of each 2017 Term E Lender to provide its applicable portion of the 2017 Term E Loans, a "***2017 Term E Commitment***"). The 2017 Term E Lenders are willing to make the 2017 Term E Loans to the Borrower on the Third Restatement Effective Date on the terms set forth herein and in the Third Restated Credit Agreement and subject to the conditions set forth herein.

The Borrower has requested that the persons set forth on Schedule III hereto (the "***2021 Term D Lenders***") commit to make 2021 Term D Loans to the Borrower on the Third Restatement Effective Date in an aggregate principal amount of $2,925,000,000 (the "***2021 Term D Loans***"; the commitment of each 2021 Term D Lender to provide its applicable portion of the 2021 Term D Loans, a "***2021 Term D Commitment***"). The 2021 Term D Lenders are willing to make the 2021 Term D Loans to the Borrower on the Third Restatement Effective Date on the terms set forth herein and in the Third Restated Credit Agreement and subject to the conditions set forth herein.

The Borrower has requested that the persons set forth on Schedule IV hereto (the "***Replacement Revolving Credit Facility Lenders***") commit to provide to the Borrower on the Third Restatement Effective Date a new senior secured revolving credit facility in an aggregate principal amount of $1,000,000,000 (the "***Replacement Revolving Credit Facility***"; the commitment of each Replacement Revolving Credit Facility Lender to provide its applicable portion of the Replacement Revolving Credit Facility, a "***Replacement Revolving Credit Facility Commitment***"). The Replacement Revolving Credit Facility Lenders are willing to provide such Replacement Revolving Credit Facility Commitments to the Borrower on the Third Restatement Effective Date on the terms set forth herein and in the Third Restated Credit Agreement and subject to the conditions set forth herein.

Each Extended Term Loan Lender that is party to this Agreement may elect to convert all (or a portion) of its Extended Term Loans into 2021 Term D Loans or into 2017 Term E Loans by executing and delivering to the Administrative Agent (or its counsel), on or prior to 12:00 p.m. (noon), New York City time, on January 17, 2014 (the "***Delivery Time***"), a signature page to this Agreement identifying itself as an Extended Term Loan Lender and specifying the amount of its Extended Term Loans that it elects to so convert; on and after the Third Restatement Effective Date, subject to the proviso to Section 3 (d)(i), (a) such portion of its Extended Term Loans as such Lender shall have specified for conversion into 2021 Term D Loans shall be 2021 Term D Loans under the Third Restated Credit Agreement and shall be subject to all terms and conditions applicable to 2021 Term D Loans as set forth in the Third Restated Credit Agreement, and (b) such portion of its Extended Term Loans as such Lender shall have specified for conversion into 2017 Term E Loans shall be 2017 Term E Loans under the Third Restated Credit Agreement and shall be subject to all terms and conditions applicable to 2017 Term E Loans as set forth in the Third Restated Credit Agreement.

Accordingly, in consideration of the foregoing and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto hereby agree as follows:

SECTION 1. Defined Terms. Capitalized terms used but not otherwise defined herein (including the Preliminary Statement hereto) shall have the meanings assigned thereto in the Third Restated Credit Agreement. The provisions of Section 1.02 of the Third Restated Credit Agreement are hereby incorporated by reference herein, *mutatis mutandis*.

SECTION 2. Amendment and Restatement of the Existing Credit Agreement. Effective as of the Third Restatement Effective Date, the Existing Credit Agreement is hereby amended and restated in the form attached hereto as Exhibit A.

SECTION 3. Transactions on the Third Restatement Effective Date. (a) 2019 Term A Loans. On the terms and subject to the conditions set forth herein, each 2019 Term A Lender agrees, severally and not jointly, to make, on the Third Restatement Effective Date, a 2019 Term A Loan to the Borrower in an aggregate principal amount equal to its 2019 Term A Commitment. The 2019 Term A Commitment of each 2019

Term A Lender shall automatically terminate upon the making of the 2019 Term A Loans on the Third Restatement Effective Date. The proceeds of the 2019 Term A Loans are to be used by the Borrower solely to pay a portion of the HMA Acquisition Costs.

(b) 2021 Term D Loans. (i) On the terms and subject to the conditions set forth herein, each 2021 Term D Lender agrees, severally and not jointly, to make, on the Third Restatement Effective Date, a 2021 Term D Loan to the Borrower in an aggregate principal amount equal to its 2021 Term D Commitment. The 2021 Term D Commitment of each 2021 Term D Lender shall automatically terminate upon the making of the 2021 Term D Loans on the Third Restatement Effective Date. The proceeds of the 2021 Term D Loans made on the Third Restatement Effective Date are to be used by the Borrower solely to pay a portion of the HMA Acquisition Costs.

(ii) On the terms and subject to the conditions set forth herein, each 2017 Term E Lender agrees, severally and not jointly, to make, on the Third Restatement Effective Date, a 2017 Term E Loan to the Borrower in an aggregate principal amount equal to its 2017 Term E Commitment. The 2017 Term E Commitment of each 2017 Term E Lender shall automatically terminate upon the making of the 2017 Term E Loans on the Third Restatement Effective Date. The proceeds of the 2017 Term E Loans made on the Third Restatement Effective Date are to be used by the Borrower solely to pay a portion of the HMA Acquisition Costs.

(c) Replacement Revolving Credit Facility; Letters of Credit. (i). On the terms and subject to the conditions set forth herein, each Replacement Revolving Credit Facility Lender agrees, severally and not jointly, to assume its Replacement Revolving Credit Facility Commitment on the Third Restatement Effective Date. On the Third Restatement Effective Date, the Revolving Credit Commitments in effect immediately prior to the occurrence of the Third Restatement Effective Date shall terminate and be replaced by the Replacement Revolving Credit Commitments. From and after the Third Restatement Effective Date, each Replacement Revolving Credit Facility Lender shall constitute a "Revolving Credit Lender", each Replacement Revolving Credit Commitment shall constitute a "Revolving Credit Commitment" and the loans made pursuant thereto shall constitute "Revolving Loans", in each case for all purposes of the Third Restated Credit Agreement and the other Loan Documents, and the Replacement Revolving Credit Facility shall have the terms that are set forth in the Third Restated Credit Agreement.

(ii) Each of Credit Suisse AG and Wells Fargo Bank, N.A., in their capacities as Issuing Banks under the Existing Credit Agreement and under the Third Restated Credit Agreement, and each Replacement Revolving Credit Facility Lender agree that notwithstanding the termination of the existing Revolving Credit Commitments, the Letters of Credit outstanding on the Third Restatement Effective Date shall remain outstanding as Existing Letters of Credit, and each Replacement Revolving Credit Facility Lender shall be deemed to have acquired a participation therein and in each Existing Letter set forth on Schedule 1.01(a) to the Third

Restated Credit Agreement in accordance with its applicable Pro Rata Percentage in effect on the Third Restatement Effective Date and in accordance with the provisions of Section 2.23 of the Third Restated Credit Agreement.

(iii) Wells Fargo Bank, N.A. agrees to act as an Issuing Bank in respect of the Replacement Revolving Credit Facility on the terms and subject to the conditions set forth herein and in the Third Restated Credit Agreement.

(iv) All Revolving Loans and Swingline Loans (such Loans, "***Existing Revolving Facility Loans***") outstanding immediately prior to the occurrence of the Third Restatement Effective Date shall be prepaid in full by the Borrower on the Third Restatement Effective Date, which prepayment shall be accompanied by accrued and unpaid interest on the Existing Revolving Facility Loans being prepaid to but excluding the Third Restatement Effective Date. Such prepayment may be financed (subject to satisfaction of applicable borrowing conditions herein) with the proceeds of Revolving Loans made on the Third Restatement Effective Date by the Replacement Revolving Credit Facility Lenders, in which case the Borrower irrevocably directs that the proceeds of such Revolving Loans be applied directly to prepay in full (and be netted against) the Existing Revolving Facility Loans, with any excess being delivered in accordance with the applicable Borrowing Request.

(d) Extended Term Loans. (i) Subject to the terms and conditions set forth herein and in the Third Restated Credit Agreement, as of the Third Restatement Effective Date, each Extended Term Loan Lender agrees that the principal amount (if any) of its Extended Term Loans specified by such Extended Term Loan Lender on the Extended Term Loan Lender Election Form delivered by it together with its executed counterpart of this Agreement will be converted into, as specified on such form, (A) 2021 Term D Loans of like outstanding principal amount and such converted Extended Term Loans shall constitute 2021 Term D Loans for all purposes under the Third Restated Credit Agreement, or (B) 2017 Term E Loans of like outstanding principal amount and such converted Extended Term Loans shall constitute 2017 Term E Loans for all purposes under the Third Restated Credit Agreement; *provided* that, in the event that the aggregate principal amount of the Extended Term Loans which Extended Term Loan Lenders agree to convert into (1) 2021 Term D Loans in accordance with the foregoing clause (A) (such Extended Term Loans being referred to herein as the "***Term D Designated Loans***") is greater than $1,676,475,699.63, the Borrower may (but shall not be obligated to) elect, by written notice to the Administrative Agent, to cause less than all (but not less than $1,676,475,699.63 aggregate principal amount) of the Term D Designated Loans to become 2021 Term D Loans, such allocation to be made on a pro rata basis among the Extended Term Loan Lenders making such an election, such that the same proportion of each such Extended Term Loan Lender's Term D Designated Loans is so converted into 2021 Term D Loans, or (2) 2017 Term E Loans in accordance with the foregoing clause (B) (such Extended Term Loans being referred to herein as the "***Term E Designated Loans***") is greater than $1,505,329,149.16 , the Borrower may (but shall not be obligated to) elect, by written notice to the Administrative Agent, to cause less than all (but not less than

$1,505,329,149.16 aggregate principal amount) of the Term E Designated Loans to become 2017 Term E Loans, such allocation to be made on a pro rata basis among the Extended Term Loan Lenders making such an election, such that the same proportion of each such Extended Term Loan Lender's Term E Designated Loans is so converted into 2017 Term E Loans.

(ii) Any Extended Term Loans that are not converted into 2021 Term D Loans or 2017 Term E Loans shall be repaid in full on the Third Restatement Effective Date.

(e) Term Loans Generally. None of the transactions set forth in this Section 3 shall be deemed to be a conversion of any Term Loan into a Loan of a different Type or with a different Interest Period or a payment or prepayment of any Term Loan, and the parties hereto hereby agree that no breakage or similar costs will accrue in respect of any Term Loan solely as a result of the transactions contemplated by this Section 3.

SECTION 4. Representations and Warranties. Each of Parent, the Borrower and each Subsidiary Guarantor hereby represents and warrants to each other party hereto that:

(a) The representations and warranties set forth in Article III of the Third Restated Credit Agreement and in each other Loan Document are true and correct in all material respects on and as of the Third Restatement Effective Date as though made on and as of such date, except to the extent that such representations and warranties expressly relate to an earlier date, in which case such representations and warranties were true and correct in all material respects as of such earlier date.

(b) No Default or Event of Default has occurred and is continuing.

(c) None of the Security Documents in effect on the Third Restatement Effective Date will be rendered invalid, non-binding or unenforceable against any Loan Party as a result of this Agreement. The Guarantees created under such Security Documents will continue to guarantee the Obligations (as the Obligations are modified hereunder and under the Third Restated Credit Agreement) to the same extent as they guaranteed the Obligations immediately prior to the Third Restatement Effective Date. The Liens created under such Security Documents will continue to secure the Obligations (as the Obligations are modified hereunder and under the Third Restated Credit Agreement), and will continue to be perfected, in each case, to the same extent as they secured the Obligations or were perfected immediately prior to the Third Restatement Effective Date. Upon the filing of the Mortgage Amendments (as defined below), the Liens created under such Security Documents will continue to secure the Obligations (as the Obligations are modified hereunder and under the Third Restated Credit Agreement), and will continue to be perfected, in each case, to the same extent as they secured the Obligations or were perfected immediately prior to the Third Restatement Effective Date.

(d) As of the Third Restatement Effective Date, no action, consent or approval of, registration or filing with or any other action by any Governmental Authority

is or will be required in connection with the execution, delivery and performance by the Loan Parties of the Loan Documents to which they are a party and the making of the Borrowings under the Third Restated Credit Agreement, except for (i) such as have been made or obtained and are in full force and effect and (ii) such actions, consents, approvals, registrations or filings which the failure to obtain or make could not reasonably be expected to result in a Material Adverse Effect.

(e) As of the Third Restatement Effective Date, the Guarantee and Collateral Agreement creates (and will create, in the case of assets of the Guarantors that are subsidiaries of Health Management Associates, Inc. (the "***Company***", and each such subsidiary, a "***Company Subsidiary Guarantor***") following the making of the filings set forth on Schedule 3.19(a) of the Third Restated Credit Agreement) in favor of the Collateral Agent, for the ratable benefit of the Secured Parties, a legal, valid and enforceable security interest in the Collateral (as defined in the Guarantee and Collateral Agreement) and the proceeds thereof, subject to the effects of bankruptcy, insolvency or similar laws affecting creditors' rights generally and general equitable principles, and (i) with respect to all Pledged Collateral (as defined in the Guarantee and Collateral Agreement) previously delivered to and in possession of the Collateral Agent, the Lien created under the Guarantee and Collateral Agreement constitutes a fully perfected first priority Lien on, and security interest in, all right, title and interest of the Loan Parties in such Pledged Collateral as to which perfection may be obtained by such actions, in each case prior and superior in right to any other person, and (ii) with the previous filing of financing statements in the offices specified on Schedule 3.19(a) of the Third Restated Credit Agreement, the Lien created under the Guarantee and Collateral Agreement constitutes a fully perfected Lien on, and security interest in, all right, title and interest of the Loan Parties in such Collateral (other than Intellectual Property, as defined in the Guarantee and Collateral Agreement) as to which perfection may be obtained by such filings, in each case prior and superior in right to any other person, other than with respect to Liens expressly permitted by Section 6.02 of the Third Restated Credit Agreement.

(f) As of the Third Restatement Effective Date, the Guarantee and Collateral Agreement, together with the filings made pursuant to the Guarantee and Collateral Agreement currently on file with the United States Patent and Trademark Office and the United States Copyright Office and the financing statements currently on file in the offices specified on Schedule 3.19(a) of the Third Restated Credit Agreement, constitutes (and will constitute, in the case of assets of the Company Subsidiary Guarantors following the making of the filings set forth on Schedule 3.19(a) of the Third Restated Credit Agreement) a fully perfected Lien on, and security interest in, all right, title and interest of the Loan Parties in the Intellectual Property (as defined in the Guarantee and Collateral Agreement) in which a security interest may be perfected by filing security agreements in the United States and its territories and possessions, in each case prior and superior in right to any other person other than with respect to Liens permitted pursuant to Section 6.02 of the Third Restated Credit Agreement (it being understood that subsequent recordings in the United States Patent and Trademark Office and the United States Copyright Office may be necessary to perfect a Lien on registered trademarks and patents, trademark and patent applications and registered copyrights acquired by the Loan Parties after the Third Restatement Effective Date).

(g) This Agreement has been duly executed and delivered by each Loan Party and constitutes a legal, valid and binding obligation of such Loan Party enforceable against such Loan Party in accordance with its terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, reorganization, moratorium, or similar laws affecting creditors' rights generally and by general principles of equity (regardless of whether enforcement is sought in a proceeding in equity or at law).

Notwithstanding anything herein to the contrary, the only representations and warranties set forth in this Section 4 the accuracy of which shall constitute a condition to the Third Restatement Effective Date (and the making of Loans on the Third Restatement Effective Date) shall be the Specified Representations (defined below).

"***Specified Representations***" means the representations and warranties set forth in (a) the Third Restated Credit Agreement in Sections 3.01 (as it relates solely to Parent and Borrower), 3.02(a) and 3.03 (solely as each of them relates to the borrowing of Loans, the guaranteeing of the Obligations, the granting of security interests in the Collateral and the performance of obligations under the Loan Documents), 3.02 (b)(i)(A), 3.11, 3.12, 3.19, 3.22 and 3.23 thereof and (b) Section (g) (solely as it relates to the Parent and Borrower) hereof.

SECTION 5. Effectiveness. This Agreement shall become effective on and as of the date on which each of the following conditions precedent is satisfied (such date, the "***Third Restatement Effective Date***"):

(a) The Administrative Agent shall have received counterparts hereof duly executed and delivered by Parent, the Borrower, each Subsidiary Guarantor and the Required Lenders.

(b) The Administrative Agent shall have received a Borrowing Request for the Loans to be made on the Third Restatement Effective Date, setting forth the information specified in Section 2.03 of the Third Restated Credit Agreement.

(c) The Administrative Agent shall have received a favorable written opinion of (i) Kirkland & Ellis LLP, counsel for Parent and the Borrower, substantially to the effect set forth on Exhibit B-1, (ii) the general counsel of Parent, substantially to the effect set forth in Exhibit B-2 and (iii) each of the other law firms set forth on Exhibit B-3, in each case in form and substance satisfactory to the Administrative Agent.

(d) The Administrative Agent shall have received (i) a certificate as to the good standing of Parent, the Borrower and (to the extent the concept of good standing is applicable in such jurisdiction) each other Loan Party as of a recent date, from the Secretary of State of its state of organization; (ii) a certificate of the Secretary or Assistant Secretary of Parent, the Borrower and each other Loan Party dated the Third Restatement Effective Date and certifying (A) that attached thereto is a true and complete copy of (1) the by-laws (or equivalent thereof) and (2) the certificate or articles of

incorporation, certified as of a recent date by the Secretary of State of the applicable state of organization, in each case of such Loan Party as in effect on the Third Restatement Effective Date and at all times since a date prior to the date of the resolutions described in clause (B) below (or, if such by-laws (or equivalent thereof) or certificate or articles of incorporation have not been amended or modified since any delivery thereof to the Administrative Agent on the Closing Date, the First Restatement Effective Date or the "Effective Date" under the Replacement Revolving Credit Facility and Incremental Term Loan Assumption Agreement dated as of March 6, 2012 (the "***First Replacement Effective Date***"), as applicable, certifying that no such amendment or modification has occurred), (B) that attached thereto is a true and complete copy of resolutions duly adopted by the Board of Directors (or equivalent thereof) of such Loan Party authorizing the execution, delivery and performance of the Loan Documents to which such person is a party, and that such resolutions have not been modified, rescinded or amended and are in full force and effect and (C) as to the incumbency and specimen signature of each officer executing this Agreement or any other document delivered in connection herewith on behalf of such Loan Party; and (iii) a certificate of another officer as to the incumbency and specimen signature of the Secretary or Assistant Secretary executing the certificate pursuant to clause (ii) above.

(e) The Administrative Agent shall have received a certificate, dated the Third Restatement Effective Date and signed by a Financial Officer of the Borrower, confirming compliance with the conditions set forth in each of paragraph (g)(i) and paragraph (i) of this Section.

(f) The Administrative Agent shall have received a certificate, dated the Third Restatement Effective Date and signed by the chief financial officer of Parent, as to the solvency of Parent and its Subsidiaries on a consolidated basis after giving effect to the Transactions to occur on the Third Restatement Effective Date, in substantially the form of Exhibit C hereto.

(g) (i) The Permitted HMA Transaction shall have been consummated, or substantially simultaneously with the initial borrowing under the Facilities, shall be consummated, in all material respects in accordance with the terms of the HMA Merger Agreement.

(ii) The Specified Merger Agreement Representations shall be true and correct. "***Specified Merger Agreement Representations***" means such of the representations made by, or with respect to, the Company and its subsidiaries in the HMA Merger Agreement as are material to the interests of the Lenders, but only to the extent that Parent (or its affiliates) have the right to terminate its (or their) obligations under the HMA Merger Agreement or to decline to consummate the Permitted HMA Transaction as a result of a breach of any one or more of such representations in the HMA Merger Agreement.

(h) Substantially simultaneously with the initial borrowing under the Facilities and the consummation of the Permitted HMA Transaction, (i) the HMA Refinancing shall have been consummated and (ii) all the Incremental Term Loans,

Non-Extended Term Loans, Extended Term Loans that are not converted to either 2021 Term D Loans or 2017 Term E Loans on the Third Restatement Effective Date, Revolving Loans and Swingline Loans (each as defined in the Existing Credit Agreement) outstanding on the Third Restatement Effective Date shall have been prepaid in full, together with all accrued and unpaid interest on the principal amount thereof to but excluding the Third Restatement Effective Date.

(i) Since July 29, 2013, there shall not have occurred any Company Material Adverse Effect.

"***Company Material Adverse Effect***" means any effect, change, event, circumstance or occurrence that, individually or in the aggregate, has had or would reasonably be expected to have a material adverse effect on the business, results of operations, assets or financial condition of the Company and its Subsidiaries (as defined in the HMA Merger Agreement as in effect on July 29, 2013), taken as a whole; provided, however, that none of the following, and no effect, change, event, circumstance or occurrence arising out of, or resulting from, the following, shall constitute or be taken into account, individually or in the aggregate, in determining whether a Company Material Adverse Effect has occurred or would reasonably be expected to occur: (A) changes generally affecting the economy, credit or financial or capital markets, in the United States or elsewhere in the world, including changes in interest or exchange rates; (B) changes generally affecting the industries in which the Company and its Subsidiaries operate; (C) changes or prospective changes in Applicable Law (as defined in the HMA Merger Agreement as in effect on July 29, 2013) or GAAP (as defined in the HMA Merger Agreement as in effect on July 29, 2013) or in accounting standards, or any changes or prospective changes in the interpretation or enforcement of any of the foregoing, or any changes or prospective changes in general legal, regulatory or political conditions; (D) changes caused by the negotiation, execution, announcement or performance of the HMA Merger Agreement (as in effect on July 29, 2013) or the consummation of the transactions contemplated thereby, or the identity of any party thereto, including the impact thereof on relationships, contractual or otherwise, with customers, suppliers, distributors, partners, employees or Governmental Entities (as defined in the HMA Merger Agreement as in effect on July 29, 2013), or any litigation arising from allegations of breach of fiduciary duty or violation of Applicable Law relating to the HMA Merger Agreement (as in effect on July 29, 2013) or the transactions contemplated thereby; (E) acts of war (whether or not declared), sabotage or terrorism, or any escalation or worsening of any such acts of war (whether or not declared), sabotage or terrorism; (F) volcanoes, tsunamis, pandemics, earthquakes, floods, storms, hurricanes, tornados or other natural disasters; (G) any action taken by the Company or its Subsidiaries that is required by the HMA Merger Agreement (as in effect on July 29, 2013) or with the prior written consent or at the direction of the Borrower in accordance with the HMA Merger Agreement (as in effect on July 29, 2013), or the failure to take any action by the Company or its Subsidiaries if that action is prohibited by the HMA Merger Agreement (as in effect on July 29, 2013); (H) changes or prospective

changes in the Company's credit ratings; (I) changes in the price or trading volume of the Company's Common Stock (as defined in the HMA Merger Agreement as in effect on July 29, 2013); or (J) any failure to meet any internal or public projections, forecasts, guidance, estimates, milestones, budgets or internal or published financial or operating predictions of revenue, earnings, cash flow or cash position (it being understood that the exceptions in clauses (H), (I) and (J) shall not prevent or otherwise affect a determination that the underlying cause of any such change or failure referred to therein (to the extent not otherwise falling within any of the exceptions provided by clauses (A) through (J) hereof) is, may be, contributed to or may contribute to, a Company Material Adverse Effect); provided further, however, that any effect, change, event or occurrence referred to in clauses (A), (B), (C), (E) or (F) may be taken into account in determining whether or not there has been or may be a Company Material Adverse Effect to the extent such effect, change, event, circumstance or occurrence has a material disproportionate adverse effect on the Company and its Subsidiaries, taken as a whole, as compared to other participants in the industries in which the Company and its Subsidiaries operate.

(j) The Security Documents (other than the Mortgage Amendments contemplated by Section 7(b) below and the new Mortgages contemplated by Section 7(c) below) shall be in full force and effect on the Third Restatement Effective Date, and, in the case of assets of Parent, the Borrower and the Subsidiary Guarantors that are not Company Subsidiary Guarantors, the Collateral Agent on behalf of the Secured Parties shall have a security interest in the Collateral of the type and priority described in each Security Document. All documents and instruments required to create and perfect the Collateral Agent's security interests in the Collateral (other than in any parcel of real property, the requirements in respect of which are set forth in Section 7(c)) held by the Company Subsidiary Guarantors shall have been executed and delivered and, if applicable, be in proper form for filing (or arrangements reasonably satisfactory to the Administrative Agent and the Collateral Agent shall have been made for the execution, delivery and filing of such documents and instruments substantially concurrently with the consummation of the Permitted HMA Transaction). Notwithstanding anything herein to the contrary, to the extent that any security interest in any Collateral that is not or cannot be provided and/or perfected on the Third Restatement Effective Date (other than the pledge and perfection of the security interests in the Pledged Collateral that constitutes certificated equity interests of HMA and, to the extent held by domestic subsidiaries of HMA that are required to become Loan Parties pursuant to Section 5.12 of the Third Restated Credit Agreement, each subsidiary of HMA and other assets pursuant to which a lien may be perfected solely by the filing of a financing statement under the Uniform Commercial Code (provided that, to the extent Parent has used commercially reasonable efforts to procure the delivery thereof prior to the Third Restatement Effective Date, certificated equity interests of HMA and its subsidiaries will only be required to be delivered on the Third Restatement Effective Date if such certificated equity interests are received from HMA)) after the Borrower's use of commercially reasonable efforts to do so or without undue burden or expense, then the provision and/or perfection of a security interest in such Collateral shall not constitute a condition to the Third Restatement Effective Date, but instead shall be required to be delivered after the Third Restatement Effective Date in accordance with Section 5.12 of the Third Restated Credit Agreement or, in the case of Collateral consisting of real property interests, Section 7 hereof.

(k) The Lead Arrangers shall have received a pro forma consolidated balance sheet and related pro forma consolidated statements of income of Parent and its subsidiaries (based on the financial statements of Parent and the Company referred to in paragraph (l) below) as of, and for the twelve-month period ending on, the last day of the most recently completed four fiscal quarter period ended at least 45 days prior to the Third Restatement Effective Date (or 90 days prior to the Third Restatement Effective Date in case such four fiscal quarter period is the end of Parent's fiscal year), prepared after giving effect to the Transactions as if the Transactions had occurred as of such date (in the case of such balance sheet) or at the beginning of such period (in the case of such statement of income).

(l) The Lead Arrangers shall have received (i) audited consolidated balance sheets of Parent and its consolidated subsidiaries and of the Company and its consolidated subsidiaries as at the end of, and related consolidated statements of income, changes in equity and cash flows of Parent and its consolidated subsidiaries and of the Company and its consolidated subsidiaries for, in each case, the three most recently completed fiscal years ended at least 90 days before the Third Restatement Effective Date and (ii) unaudited consolidated balance sheets of Parent and its consolidated subsidiaries and of the Company and its consolidated subsidiaries as at the end of, and related statements of income, changes in equity and cash flows of Parent and its consolidated subsidiaries and of the Company and its consolidated subsidiaries for, in each case, each subsequent fiscal quarter (other than the fourth fiscal quarter of any fiscal year) of Parent and its consolidated subsidiaries and of the Company and its consolidated subsidiaries ended after the last fiscal year for which financial statements were prepared pursuant to the preceding clause (i) and ended at least 45 days before the Third Restatement Effective Date; provided that the filing of the required financial statements on Form 10-K and Form 10-Q within such time periods by the Company and Parent will satisfy the requirements of this paragraph (l).

(m) The Administrative Agent and the Lead Arrangers shall have received at least three business days before the Third Restatement Effective Date all documentation and other information about the Borrower and the Guarantors that shall have been reasonably requested by the Administrative Agent or the Lead Arrangers in writing at least 10 Business Days prior to the Third Restatement Effective Date and that the Administrative Agent and the Lead Arrangers reasonably determine is required under applicable "know your customer" and anti-money laundering rules and regulations, including without limitation the PATRIOT Act, based on their reasonable interpretation of such rules and regulations.

(n) All fees agreed in writing and required to be paid on the Third Restatement Effective Date in connection with the Loans to be made on the date hereof and all reasonable out-of-pocket expenses required to be paid on the Third Restatement Effective Date, to the extent invoiced at least three business days prior to the Third Restatement Effective Date (or such shorter period agreed to by the Borrower), shall,

substantially concurrently with the making of such Loans, have been paid (which amounts may, at the option of the Borrower, be offset against the proceeds of such Loans).

(o) [reserved].

(p) The Administrative Agent shall have received payment from the Borrower, for the account of each Lender under the Existing Credit Agreement (other than any Lender that has, or is an Affiliate of a Person that has, a bookrunner, co-syndication agent, co-documentation agent or co-manager title in respect of this Amendment) that unconditionally transmits its executed counterpart of this Agreement to the Administrative Agent (or its counsel) on or prior to the Delivery Time, of an amendment fee in an amount equal to 0.15% of the aggregate principal amount of the outstanding Loans and unused Commitments of such Lender under the Third Restated Credit Agreement as of the Third Restatement Effective Date after giving effect to the HMA Refinancing. Such fees shall be payable in immediately available funds and, once paid, shall not be refundable in whole or in part.

(q) The Administrative Agent shall have received payment from the Borrower, for the account of each Extended Term Loan Lender, a fee in an amount equal to 0.25% of the aggregate principal amount of such Extended Term Loan Lender's Extended Term Loans that are converted into 2021 Term D Loans on the Third Restatement Effective Date. Such fees shall be payable in immediately available funds and, once paid, shall not be refundable in whole or in part.

The Administrative Agent shall notify the parties hereto of the Third Restatement Effective Date and such notice shall be conclusive and binding. Notwithstanding the foregoing, this Agreement shall not become effective unless each of the foregoing conditions is satisfied at or prior to 5:00 p.m. New York City time on February 28, 2014.

SECTION 6. Effect of this Agreement. (a) Except as expressly set forth herein, this Agreement shall not by implication or otherwise limit, impair, constitute a waiver of, or otherwise affect the rights and remedies of the Administrative Agent, the Lenders or any other Secured Party under the Existing Credit Agreement, the Third Restated Credit Agreement or any other Loan Document, and shall not alter, modify, amend or in any way affect any of the terms, conditions, obligations, covenants or agreements contained in the Third Restated Credit Agreement or any other Loan Document, all of which are ratified and affirmed in all respects and shall continue in full force and effect. Nothing herein shall be deemed to entitle any Loan Party to a consent to, or a waiver, amendment, modification or other change of, any of the terms, conditions, obligations, covenants or agreements contained in the Existing Credit Agreement or any other Loan Document in similar or different circumstances.

(b) On and after the Third Restatement Effective Date, each reference in the Third Restated Credit Agreement to "this Agreement", "hereunder", "hereof", "herein" or words of like import, and each reference to the "Credit Agreement" in any other Loan Document, shall be deemed a reference to the Third Restated Credit Agreement.

(c) This Agreement shall constitute a "Loan Document", a "Loan Modification Agreement" and a "Permitted Amendment" for all purposes of the Existing Credit Agreement, the Third Restated Credit Agreement and the other Loan Documents.

(d) On the Third Restatement Effective Date, the Borrower will be deemed to have given notice of (i) the prepayment in full on the Third Restatement Effective Date of the Incremental Term Loans, the Non-Extended Term Loans, the Extended Term Loans that are not converted to either 2021 Term D Loans or 2017 Term E Loans on the Third Restatement Effective Date and the Existing Revolving Facility Loans then outstanding and (ii) the termination of the Revolving Credit Commitments in effect on the Third Restatement Effective Date, in each case in accordance with this Agreement, and each of the Required Lenders under the Existing Credit Agreement, the Administrative Agent, the Collateral Agent, each Issuing Bank and the Swingline Lender waive any requirement for any other notice of such prepayment and termination.

SECTION 7. Reaffirmation. (a) Each of Parent, the Borrower and each of the Subsidiary Guarantors identified on the signature pages hereto (collectively, Parent, the Borrower and such Subsidiary Guarantors (other than the Company Subsidiary Guarantors), the "***Reaffirming Loan Parties***") hereby acknowledges that it expects to receive substantial direct and indirect benefits as a result of this Agreement and the transactions contemplated hereby. Each Reaffirming Loan Party hereby consents to this Agreement and the transactions contemplated hereby, and hereby confirms its respective guarantees (including in respect of the 2019 Term A Loans, the 2021 Term D Loans, the 2017 Term E Loans and the Replacement Revolving Credit Facility), pledges and grants of security interests, as applicable, under each of the Loan Documents to which it is party, and agrees that, notwithstanding the effectiveness of this Agreement and the transactions contemplated hereby, such guarantees, pledges and grants of security interests shall continue to be in full force and effect and shall accrue to the benefit of the Secured Parties (including in respect of the 2019 Term A Lenders, the 2021 Term D Lenders, the 2017 Term E Lenders and the Replacement Revolving Credit Facility Lenders). Each of the Reaffirming Loan Parties further agrees to take any action that may be required or that is reasonably requested by the Administrative Agent to effect the purposes of this Agreement, the transactions contemplated hereby or the Loan Documents and hereby reaffirms its obligations under each provision of each Loan Document to which it is party.

(b) Within 180 days after the Third Restatement Effective Date (or such later date as the Administrative Agent in its sole discretion may permit) the Borrower shall deliver, with respect to each Mortgage encumbering a Mortgaged Property, an amendment or an amendment and restatement thereof (each, a "***Mortgage Amendment***"), setting forth such changes as are reasonably necessary to reflect that the lien securing the Obligations under the Third Restated Credit Agreement encumbers such Mortgaged Property and to further grant, preserve, protect, confirm and perfect the first-priority lien and security interest thereby created and perfected, and opinions by local counsel

reasonably acceptable to the Administrative Agent regarding the enforceability of each such Mortgage Amendment, together with modification and datedown endorsements to existing title policies to the extent available (or, to the extent not available, new title policies) and flood determinations and flood insurance as required by Regulation H, each of the foregoing being in all respects reasonably acceptable to the Administrative Agent.

(c) Within 180 days after the Third Restatement Effective Date (or such later date as the Administrative Agent in its sole discretion may permit) the Borrower shall deliver, with respect to each parcel of real property held by any Company Subsidiary Guarantor (other than those expressly exempt from the mortgage requirements pursuant to the antepenultimate sentence of Section 2.12 of the Third Restated Credit Agreement), a mortgage, deed of trust or other applicable instrument which shall create and perfect a first-priority lien and security interest on such parcel of real property securing the Obligations under the Third Restated Credit Agreement, together with opinions by local counsel reasonably acceptable to the Administrative Agent regarding the enforceability of each such Mortgage, together with title policies and flood determinations and flood insurance as required by Regulation H, each of the foregoing being in all respects reasonably acceptable to the Administrative Agent.

SECTION 8. [reserved]

SECTION 9. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. Delivery by electronic transmission of an executed counterpart of a signature page to this Agreement shall be effective as delivery of an original executed counterpart of this Agreement.

SECTION 10. No Novation. Neither this Agreement nor the effectiveness of the Third Restated Credit Agreement shall extinguish the obligations for the payment of money outstanding under the Existing Credit Agreement or discharge or release the Lien or priority of any Loan Document or any other security therefor or any guarantee thereof. Nothing herein contained shall be construed as a substitution or novation of the Obligations outstanding under the Existing Credit Agreement or instruments guaranteeing or securing the same, which shall remain in full force and effect, except as modified hereby or by instruments executed concurrently herewith. Nothing expressed or implied in this Agreement, the Third Restated Credit Agreement or any other document contemplated hereby or thereby shall be construed as a release or other discharge of the Borrower under the Existing Credit Agreement or any Loan Party under any other Loan Document from any of its obligations and liabilities thereunder. The Existing Credit Agreement and each of the other Loan Documents shall remain in full force and effect, until and except as modified hereby or thereby in connection herewith or therewith.

SECTION 11. Governing Law. (a) THIS AGREEMENT SHALL BE GOVERNED BY, AND CONSTRUED IN ACCORDANCE WITH, THE LAWS OF THE STATE OF NEW YORK; *provided, however*, that it is understood and agreed that (a) the interpretation of the definition of "Company Material Adverse Effect" (and

whether or not a Company Material Adverse Effect has occurred) and (b) the determination of whether the Permitted HMA Transaction has been consummated in accordance with the terms of the HMA Merger Agreement, in each case shall be governed by, and construed in accordance with, the laws of the state of Delaware, regardless of the laws that might otherwise govern under applicable principles of conflicts of laws thereof.

(b) EACH PARTY HERETO HEREBY WAIVES, TO THE FULLEST EXTENT PERMITTED BY APPLICABLE LAW, ANY RIGHT IT MAY HAVE TO A TRIAL BY JURY IN ANY LEGAL PROCEEDING DIRECTLY OR INDIRECTLY ARISING OUT OF OR RELATING TO THIS AGREEMENT OR THE TRANSACTIONS CONTEMPLATED HEREBY (WHETHER BASED ON CONTRACT, TORT OR ANY OTHER THEORY). EACH PARTY HERETO (I) CERTIFIES THAT NO REPRESENTATIVE, AGENT OR ATTORNEY OF ANY OTHER PARTY HAS REPRESENTED, EXPRESSLY OR OTHERWISE, THAT SUCH OTHER PARTY WOULD NOT, IN THE EVENT OF LITIGATION, SEEK TO ENFORCE THE FOREGOING WAIVER AND (II) ACKNOWLEDGES THAT IT AND THE OTHER PARTIES HERETO HAVE BEEN INDUCED TO ENTER INTO THIS AGREEMENT BY, AMONG OTHER THINGS, THE MUTUAL WAIVERS AND CERTIFICATIONS IN THIS SECTION.

SECTION 12. Headings. Section headings used herein are for convenience of reference only, are not part of this Agreement and shall not affect the construction of, or be taken into consideration in interpreting, this Agreement.

[*Remainder of page intentionally left blank*]

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be duly executed by their respective authorized officers as of the date first above written.

CHS/COMMUNITY HEALTH SYSTEMS, INC.,

by /s/ Rachel A. Seifert
Name: Rachel A. Seifert
Title: Executive Vice President and Secretary

COMMUNITY HEALTH SYSTEMS, INC.,

by /s/ Rachel A. Seifert
Name: Rachel A. Seifert
Title: Executive Vice President and Secretary

COPY-
Additional Info.
SUPPLEMENTAL-2

Tennova Healthcare
CN1408-034

CREDIT SUISSE

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Eleven Madison Avenue Phone 212 325 2000
New York, NY 10010-3629
www.credit-suisse.com

August 28, 2014

State of Tennessee
Health Services and Development Agency
Andrew Jackson State Office Building
Nashville, TN 37243

RE: Credit Worthiness
Certificate of Need Application CN1408-034
Tennova Healthcare Nursing Home

Dear Sir:
Pursuant to your request and according to the terms of Amended and Restated Credit Agreement dated January 27, 2014 among CHS/Community Health Systems Inc. and Credit Suisse AG, as Administrative Agent and Collateral Agent, this will confirm that, as of the date of this letter, CHS/Community Health Systems, Inc. has funds available under a 1 Billion Revolving Credit Agreement with terms as follows:

Available Amount:	$740,000,000
Revolver Maturity Date:	January 27, 2019
Current Projected Interest Rate:	4.75% Prime + Margin (Same Day Borrowing)
	2.74% LIBOR + Margin (3 Day Notice Borrowing)

No Restrictions currently exist.
Regards,

Ramish Aiman
[illegible] Authorized Signatory

Cc: Anita H Passarella
Director Cash Management, Community Health Systems Inc.

LETTER OF INTENT
TENNESSEE HEALTH SERVICES AND DEVELOPMENT AGENCY

The Publication of Intent is to be published in the **Knoxville News Sentinel** which is a newspaper
(Name of Newspaper)
of general circulation in **Knox County**, Tennessee, on or before **August 8, 2014**, for one day.
(County) (Month / day)(Year)

==========

This is to provide official notice to the Health Services and Development Agency and all interested parties, in accordance with T.C.A. § 68-11-1601 *et seq.*, and the Rules of the Health Services and Development Agency, that: **Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare – Physicians Regional Medical Center, Hospital**
(Name of Applicant) (Facility Type-Existing)

owned by: **Knoxville HMA Holdings, LLC,** with an ownership type of **Limited Liability Corporation** and to be managed by: **Community Health Systems Professional Services Corporation** intends to file an application for a Certificate of Need

for: **relocating the Tennova Healthcare – Physicians Regional Medical Center 25-bed nursing home from the existing campus of Physicians Regional Medical Center, currently located at 900 E. Oak Hill Avenue, Knoxville, TN 37917, to the currently unaddressed site of a proposed replacement hospital at the intersection of Middlebrook Pike and Old Weisgarber Road, across from Dowell Springs Boulevard in Knoxville. A separate Certificate of Need application is being filed for the replacement and relocation of the hospital. The nursing home beds would be located in a unit that will be constructed as part of the proposed replacement hospital, on Middlebrook Pike at its intersection with Dowell Springs Boulevard in Knoxville. No new beds or new healthcare services are proposed in this project. The anticipated total cost of the project is $6,454,796.**

The anticipated date of filing the application is: **August 13, 2014**

The contact person for this project is **Melanie Burgess** (Contact Name) **Asst. Vice President** (Title)

who may be reached at: **Tennova Healthcare – Physicians Regional Medical Center** (Company Name)
930 Emerald Ave., POB Suite 813 (Address)

Knoxville (City) **Tennessee** (State) **37919** (Zip Code) **865 / 647-5604** (Area Code / Phone Number)

(Signature) **August 6, 2014** (Date) **melanie.burgess@hma.com** (E-mail Address)

==========

The Letter of Intent must be filed in triplicate and received between the first and the tenth day of the month. If the last day for filing is a Saturday, Sunday or State Holiday, filing must occur on the preceding business day. File this form at the following address:

Health Services and Development Agency
Andrew Jackson Building
500 Deaderick Street, Suite 850
Nashville, Tennessee 37243

==========

The published Letter of Intent must contain the following statement pursuant to T.C.A. § 68-11-1607(c)(1). (A) Any health care institution wishing to oppose a Certificate of Need application must file a written notice with the Health Services and Development Agency no later than fifteen (15) days before the regularly scheduled Health Services and Development Agency meeting at which the application is originally scheduled; and (B) Any other person wishing to oppose the application must file written objection with the Health Services and Development Agency at or prior to the consideration of the application by the Agency.

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Affidavits: 1

TN HEALTH SERVICES & DEVELOPME
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ANDREW JACKSON OFC BLDG
NASHVILLE, TN 37243

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To: TN HEALTH SERVICES & DEVELOPMENT AGENCY

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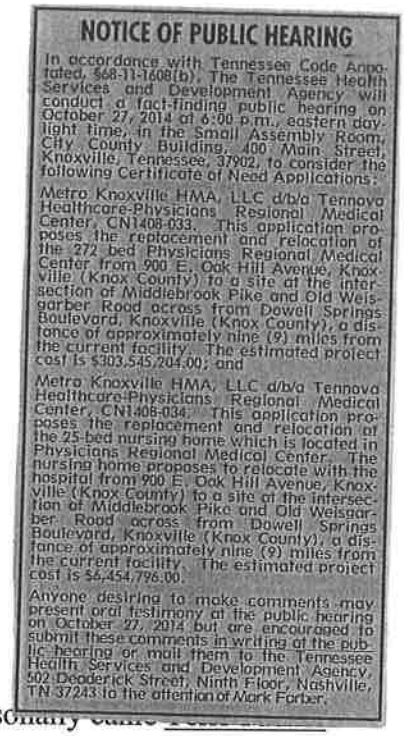

NOTICE OF PUBLIC HEARING

In accordance with Tennessee Code Annotated, §68-11-1608(b), The Tennessee Health Services and Development Agency will conduct a fact-finding public hearing on October 27, 2014 at 6:00 p.m., eastern daylight time, in the Small Assembly Room, City County Building, 400 Main Street, Knoxville, Tennessee, 37902, to consider the following Certificate of Need Applications:

Metro Knoxville HMA, LLC d/b/a Tennova Healthcare-Physicians Regional Medical Center, CN1408-033. This application proposes the replacement and relocation of the 272 bed Physicians Regional Medical Center from 900 E. Oak Hill Avenue, Knoxville (Knox County) to a site at the intersection of Middlebrook Pike and Old Weisgarber Road across from Dowell Springs Boulevard, Knoxville (Knox County), a distance of approximately nine (9) miles from the current facility. The estimated project cost is $303,545,204.00; and

Metro Knoxville HMA, LLC d/b/a Tennova Healthcare-Physicians Regional Medical Center, CN1408-034. This application proposes the replacement and relocation of the 25-bed nursing home which is located in Physicians Regional Medical Center. The nursing home proposes to relocate with the hospital from 900 E. Oak Hill Avenue, Knoxville (Knox County) to a site at the intersection of Middlebrook Pike and Old Weisgarber Road across from Dowell Springs Boulevard, Knoxville (Knox County), a distance of approximately nine (9) miles from the current facility. The estimated project cost is $6,454,796.00.

Anyone desiring to make comments may present oral testimony at the public hearing on October 27, 2014 but are encouraged to submit these comments in writing at the public hearing or mail them to the Tennessee Health Services and Development Agency, 502 Deaderick Street, Ninth Floor, Nashville, TN 37243 to the attention of Mark Farber.

PUBLISHER'S AFFIDAVIT

State of Tennessee }

s.s

County of Knox }

Before me, the undersigned, a Notary Public in and for said county, this day personally came [illegible] first duly sworn, according to law, says that he/she is a duly authorized representative of *The Knoxville News-Sentinel*, a daily newspaper published at Knoxville, in said county and state, and that the advertisement of :

(The Above-Referenced)

of which the annexed is a copy, was published in said paper on the following date(s):

October 14, 2014

and that the statement of account herewith is correct to the best of his/her knowledge, information, and belief.

Jan Ingle

Subscribed and sworn to before me this 14th day of October 20 14

Rebecca D Spann

Notary Public

My commission expires November 20 14

STATE OF TENNESSEE NOTARY PUBLIC

Tennessee Health Services and Development Agency
Public Hearing
October 27, 2014
Metro Knoxville HMA, LLC d/b/a
Tennova Healthcare-Physicians Regional Medical Center
CN1408-033 & CN1408-034

AGENCY STAFF PRESENT

Mark Farber, Deputy Director
Jim Christoffersen, General Counsel
Rhonda Finchum, Director of Administrative Services
Mark Ausbrooks, Administrative Assistant 1

ATTENDEES PRESENT

Support
Warren Gooch, Esq
Neil Heatherly, CEO, TENNOVA
Jerry Askew
Barb Wright
Karen Metz
Shelly Fawler
Lori Coffey
Dan McGraw
Timothy Henion
Frank Beurlein
Jim Beaugard
Pam Beck
David Johnson
Donnie Ernst
Barbara Pelot
Reuben Pelot
Philip Harn
Jared Amerson
Chris Defranco
Neil Hartwig
Kristen Kilgore
Leonard Brabson
Tammy White
Rhonda Maynard
Sandy Robinson
Becky Dodson
Leigh Dunlap
Brenda Neely

Opposition
Darrell Hurley
Katy Gooch
Andrea Ray
Rocky Swingle
Larry Silverstein
Juanita Davis-Braswell
Charles Braswell
Larry Hill
Charles Thomas
Jan Etheridge
Susie Smith
Nick Della Volpe
Dana Fox
Anne Crais
Timothy Crais
Sue Stephens
Ben Gooch
Charlotte Davis
Carlene Malone
AB Kliefoth
Patty Earl
Dennis Earl
Teresa Hurley
Darrell Hurley Sr
Alan Krichinsky
Don Hinton
Ella Hinton
Mille Hill
Alice Fox
Gael Lott
April Hurley
Michael Covington
Gregory Pitts
Iva Hurley
Michael Covington

Neutral
Lee Hume

CALL TO ORDER /ANNOUNCEMENTS:

The public hearing was called to order by Mark Farber, Deputy Director, on October 27, 2014 at 6:00 p.m., in the Small Assembly Room, City County Building, 400 Main Street, Knoxville, Tennessee, 37902, regarding the following Certificate of Need Applications: CN1408-033 TENNOVA Healthcare Physicians Regional Medical Center and CN1408-034 TENNOVA Healthcare Nursing home.

Mr. Farber provided instructions for those speaking about the applications.

Mr. Farber informed the audience that this was a fact-finding public hearing and the applications will be presented to the Agency members for review at the November 19, 2014 Health Services and Development Agency Meeting in Nashville, TN.

Jim Christoffersen, General Counsel, explained the process of filing support and/or opposition with the Health Services and Development Agency, legal requirements for being eligible to file for an administrative appeal of the Agency's decision to approve or deny the applications, and the administrative appeal process.

APPLICANT'S PRESENTATION:

Neal Heatherly, Chief Executive Officer, TENNOVA Healthcare representing the applicant, addressed the staff and audience stating that current models for efficiency at St. Marys Medical Center are antiquated and it would not be financially feasible to rebuild on the current location. Mr. Heatherly also stated the new facility was mandated by the medical staff as the growing population of the Knoxville area continues to make strides. Further detail is available in the written presentations made to the Agency in the Certificate of Need Applications. Further comments will be presented at the November 19, 2014 HSDA Meeting.

MEMBERS OF THE COMMUNITY (SUPPORT):

Dr. Leonard Brabson: Due to inefficiencies in the current facility, he has to take three different elevators to reach the Maternity Ward. There are multiple issues with this as it could mean a difference between life and death.

Dr Frank Beurlein, Laboratory Director Chairman of Physicians leadership counsel: The hospital has outlived its usefulness, and the majority of physicians are actively in favor of a replacement facility. Placing new technologies into an antiquated facility would not make for an orderly health facility.

Jerry Askew, Vice President of External Relations: Physician's Regional Medical Center is unable to be a state leader in its current facility. The board has mandated replacing the current facility with a more technologically advanced facility.

Reuben Pelot, past president of the West Hills Community Association: Mr. Pelot and his wife Barbara are in support of the Middlebrook location; Mrs. Pelot monitored the Tennova transition plans as a city council member (now former). Tennova has kept the neighborhood well informed of the plans for an updated facility, and has worked with the West Hills Community Association by making changes to the project's footprint. Tennova will maintain 40% of the property as a nature preserve. The West Hills Community Association endorses the application. Tennova needs to move, and the Dowell Springs location is near three nursing homes.

Sandy Robinson: She does not believe Tennova would be a major concern for traffic. Mrs. Robinson believes that owners of private property have a right to develop, and the opposition is opposition to development. She also states Tennova has acquiesced to neighborhood requests for changes to the development plans, such as moving the helicopter site to the east side due to noise concerns.

Speakers in Opposition:

(Opposition focused upon the TENNOVA Healthcare Physicians Regional Medical Center application, and specifically upon the relocation of the hospital from its current site to the proposed site)

Larry Silverstein, Esq., resident of West Hills and representing Friends of Middlebrook (which he states includes 700+ people): Mr. Silverstein read into the record most of the letter that he submitted in opposition to the project; a copy of the letter is included in materials provided to Agency members.

Rocky Swingle (Friends of Middlebrook, Wesley Neighbors and Pembroke Community): Mr. Swingle summarized neighborhood opposition to the project, including letters, signs, a petition, the West Hills Community Association and Wesley Neighbors votes against the project. Mr. Swingle stated the proposed location would harm the community by reducing property values, increasing traffic congestion, imposing three years of construction nuisance, increasing flooding, and destroying a wildlife habitat.

Mr. Swingle also stated that the application contradicts statements and assumptions contained in the facility's 2004 application, which acknowledged that west Knoxville was overcrowded in terms of hospitals. Mr. Swingle stated that west Knoxville is already well served by existing hospitals, whereas north Knoxville would lose its only hospital and access if the application to relocate were approved. He discussed social and economic differences between the current hospital site and West Knoxville. He accused Tennova of abandoning poor and minority patients. He argued that Tennova has misstated the PRMC (f/k/a "St. Mary's) service area as being 15 counties, when it is primarily north and east Knoxville and outlying counties.

Mr. Swingle advocated renovating the current PRMC facility as a "workable alternative," with the transfer of some beds to the Emory Road location to decompress the facility.

Councilman Nick Della Volpe, who represents the 4th district in East Knoxville: He stated that the current PRMC facility provides important services for the north/east Knoxville area, and that an extra 15-20 minute drive would diminish access to care for his constituents. He stated that Tennova's desire to move West was financially driven. He lamented the current state of the health care system that seems to drive hospitals away from needy communities like East Knoxville in order to make a profit from wealthier communities like West Knoxville. He is concerned about the negative economic impact upon north Knoxville.

Dana Fox complained that the vast majority of people were not made aware of the public hearing, and stated there has been very limited coverage from the media, and stated (erroneously) that notice had not been published in the newspaper. He argued that it would be poor health planning to move a hospital away from where the patients it currently serves are located, and that it's where it is because the people there need it. He likened the placement of hospitals near the need to having a fire station where needed. He expressed concern that the population being served now, including poor citizens, will be left without access to a hospital and the doctors who will leave with it.

Darrell Hurley, representing Justice for Valerie Hurley: Mr. Hurley discussed the passing of his sister at a Tennova hospital, and the government investigation and private lawsuit that followed (in which a multi-million dollar judgement was awarded to her family). He discussed a D.O.J. action against HMA, which owned Tennova prior to CHS. Mr. Hurley stated that "St. Mary's" (PRMC) scores poorly in rankings.

Ann Crais, representing Wesley Neighbors Neighborhood Association: Ms. Crais read a letter from Wesley Neighbors Community Association's John Heins, stating that WNCA members voted to oppose the project by a margain of 91-7, with 4 undecided.

Tom McDaniel stated that his property was surrounded on three sides by the proposed location, and the new location of the helicopter pad would be below his living room window. He implored the Agency to consider the negative impact upon neighbors such as himself.

Michael Covington (of east Knoxville) expressed frustration with moving the hospital "nine miles west" from where it is needed by Tennova for only its own benefit (profit). He also expressed frustration with the doctors who have been described as wanting to leave east Knoxville.

Charlotte Davis stated that approval of the application would leave north and east Knoxville without a full service hospital, where it's needed, and reduce access there and impose a "9-11 mile trek" (further on those who come from outlying counties), which isn't easy and "could mean life and death." She stated that the real service area is north and east Knoxville, not 15 counties. Mrs. Davis stated that there's already ample hospital capacity in west Knoxville, but approval of the application would leave north Knoxville without any. Mrs. Davis recommends the expansion of the North Knoxville Hospital, versus moving of the facility to Middlebrook.

Andrea Ray, President of the Old North Knox Neighborhood Association: Ms. Ray stated that the community's needs should be considered, not just Tennova's needs. She stated that access to the proposed location would require a bus ride with two to three transfers from the current location. She stated that the application admits this is a busy hospital (at its current location). She stated that going from 4 to 5 hospitals in west Knoxville while going from 1 to 0 in north Knoxville should not be done.

Katherine Gooch stated that she was born at St. Mary's 82 years ago, that several of her family members have been born, died, had surgery, and been cured of various issues at the hospital's current location. She stated that the need for the hospital is where it is located, and that something should be done at the current location rather than abandoning it and the area's residents.

Dr. A.B. Kliefoth, "on staff at St. Mary's (PRMC) since 1981," though not on active staff, opposed the hospital's relocation for the following reasons. NEED – He echoed the comments made earlier in the evening about there being no need for another hospital in west Knoxville, and stated: the proposed hospital is not wanted in west Knoxville, it is needed in north Knoxville – especially by the elderly and poor there who aren't as mobile, land is available in north Knoxville, and that doctors have left the hospital due to bad decisions made by its prior administration and due to being forced into providing call at St. Mary's (PRMC) as well as other hospitals. ORDERLY DEVELOPMENT – Relocating from where the hospital is needed to where it is not, relocating from the less affluent to the more affluent, and adding to the "arms race" in west Knoxville would not contribute to the orderly development of healthcare. ECONOMIC FEASABILITY – He stated that doing something on the current location

would make more sense financially. Also, he stated that CMS is discouraging hospital admissions and length of stay, which will mean reduced need for beds and an over-abundance of them.

Lee Hume asked that a letter be entered into the record.

Additional letters of opposition were submitted from: Larry Silverstein, Esq., Darrell Hurley, Charlotte Davis, Ashley Williams, Anne Crais, Beverly Gooch, Katherine Gooch, and John Heins.

Applicant's Response:

Melanie Burgess, Assistant Vice President Business Development, Tennova Market Support Office: Ms. Burgess stated that Tennova has worked diligently for 18 months with multiple meetings and listening to the concerns of the dialogue of neighbors. Tennova is committed to a number of items specifically preserving forty percent of the acreage for the greenways and wildlife. Tennova has met with the city to ensure codes will be met. The project will be thoroughly detailed at the November 19, 2014 Meeting.

ADJOURNMENT

Mark Farber adjourned the Public Hearing at 9:00 p.m.

Mark Farber, Deputy Executive Director
MF/maa

CERTIFICATE OF NEED
REVIEWED BY THE DEPARTMENT OF HEALTH
DIVISION OF POLICY, PLANNING AND ASSESSMENT
615-741-1954

DATE: October, 31, 2014

APPLICANT: Metro Knoxville HMA, LLC,
d/b/a Tennova Healthcare-Physician's Regional Medical Center
Unaddressed site at the intersection of Middlebrook Pike
and Old Weisgarber Road
Knoxville, Tennessee 37917

CN1408-034

CONTACT PERSON:
Melanie Burgess, Assistant Vice President
Tennova Healthcare-Physician's Regional Medical Center
930 Emerald Avenue, POB Suite 813
Knoxville, Tennessee 37919

COST: $6,454,796

In accordance with Section 68-11-1608(a) of the Tennessee Health Services and Planning Act of 2002, the Tennessee Department of Health, Division of Policy, Planning, and Assessment, reviewed this certificate of need application for financial impact, TennCare participation, compliance with *Tennessee's State Health Plan*, and verified certain data. Additional clarification or comment relative to the application is provided, as applicable, under the heading "Note to Agency Members."

SUMMARY:
The applicant, Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare-Physicians Regional Medical Center (PRMC), located in Knoxville (Knox County), Tennessee, seeks Certificate of Need (CON) approval for the relocation of its 25-bed nursing home from 900 E. Oak Hill Avenue, Knoxville to a currently unaddressed site at the intersection of Middlebrooke Pike and Old and Old Weisgarber Road, across from Dowell Springs Boulevard in Knoxville. This project does not add any new beds to the service area or any new healthcare services.

This project is in conjunction with CN1408-033, which involves the construction and equipping of PRMC, a 556,083 square foot replacement hospital consisting of 272 beds from the existing Oak Hill campus' 401 licensed beds and 24 operating/procedure rooms.

The proposed replacement nursing facility will consist of 25 skilled nursing beds in 19,650 square feet of space on the fourth floor of the replacement hospital, including therapy gym space. The total cost for construction is $5,895,000, or $300 per square foot.

Physicians Regional Medical Center is the main location of Metro Knoxville HMA, LLC, d/b/a Tennova Healthcare. In Metro Knoxville, the hospital provides inpatient care on three campuses, PRMA, North Knoxville Medical Center, and Turkey Creek Medical Center. These three campuses operate under a single hospital license and Medicare provider number

Metro Knoxville HMA, LLC, is a wholly owned subsidiary of CHS/Community Health Systems, Inc., with corporate offices in Franklin, Tennessee. The ownership listing is located in Attachment B.I Project Description 3.

The total project cost is $6,454,796 and will be funded through capital provided by CHS/Community Health Systems, Inc. Attachment C. Economic Feasibility-2 contains a letter from the Chief Financial Officer attesting to the availability of capital for this project. Additionally, the

applicant notes a $700,000 revolving line of credit exists if in the event current cash reserves are not sufficient.

GENERAL CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all of the general criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

NEED:
The applicant's 15 county service area population projections are illustrated below.

Service Area Total Population Projections for 2014 and 2018

County	2014 Population	2018 Population	% Increase or (Decrease)
Anderson	76,579	77,851	1.7%
Blount	128,368	135,171	5.3%
Campbell	41,474	42,566	2.6%
Claiborne	32,604	33,280	2.1%
Cocke	36,762	38,615	5.0%
Grainger	23,111	23,675	2.4%
Hamblen	64,108	65,570	2.3%
Jefferson	53,729	56,872	5.8%
Knox	453,629	475,569	4.8%
Loudon	50,926	53,192	4.4%
Monroe	46,092	48,088	4.3%
Roane	54,006	54,457	0.8%
Scott	21,944	21,969	0.1%
Sevier	94,833	100,362	5.8%
Union	19,301	19,605	1.6%
Total	**1,197,466**	**1,246,842**	**4.0%**

Source: *Tennessee Population Projections 2000-2020, February 2013 Revision*, Tennessee Department of Health, Division of Health Statistics

Service Area 65+ Population Projections for 2014 and 2018

County	2014 Population	2018 Population	% Increase or (Decrease)
Anderson	14,531	16,277	12.0%
Blount	23,120	25,829	11.7%
Campbell	7,614	8,122	6.7%
Claiborne	5,880	6,378	8.5%
Cocke	6,669	6,871	3.0%
Grainger	4,204	4,557	8.4%
Hamblen	11,269	12,067	7.1%
Jefferson	9,972	11,291	13.2%
Knox	66,392	78,354	18.0%
Loudon	12,711	14,179	11.5%
Monroe	8,938	10,340	15.7%
Roane	11,422	12,508	9.5%
Scott	3,541	3,857	8.9%
Sevier	16,768	19,252	14.8%
Union	3,171	3,660	15.4%
Total	**206,202**	**233,542**	**13.3%**

Source: *Tennessee Population Projections 2000-2020, February 2013 Revision*, Tennessee Department of Health, Division of Health Statistics

The entire replacement project includes construction and equipping a 556,083 square foot

replacement hospital consisting of 272 beds of the existing Oak Hill campus' 401 licensed beds and 24 operating/procedure rooms. Designated health services that will be relocated are acute care services, obstetrical services, critical care services, Level IIB neonatal nursery services, cardiac catheterization extra-corporeal shock wave therapy lithotripsy services, open heart surgery, inpatient rehabilitation services, radiation services; and the 25-bed skilled nursing unit, licensed under a separate license.

The existing facility consists of 917,235 square feet of hospital space, plus another 624,265 of medical office building and parking space on 21 acres. The facility is licensed for 401 beds, with separate licenses for 25 skilled nursing beds and 18 residential hospice beds. The existing hospital consists of 13 buildings that are all interconnected with the exception of the outpatient surgery center.

The applicant wants to retain the 38 psychiatric beds and 91 medical surgery beds at the Oak Hill campus. Currently the applicant is conducting a comprehensive bed need analysis across its three campuses as part of a long range plan. Once this is completed, and prior to implementation of the CON for the replacement facility, PRMC will either obtain a waiver from the Tennessee Department of Health to retain the beds in an inactive status or file additional applications for the relocation of licensed beds to its other facilities; or de-license the 91 beds.

PRMC's 450 member medical staff has overwhelmingly voiced their concern over the existing hospital facility. Their patient's find the facility unacceptable and they are choosing to receive care in newer and more accessible environments. Many physicians have relocated their offices away due to the age and inaccessibility and feedback from patients.

This application simply seeks to relocate the existing skilled nursing beds to the new replacement hospital campus. The proposed skilled nursing unit is larger than the current unit in order to allow for a larger therapy gym, as well as to provide ADA-compliant bathrooms and a shower in each patient room.

The skilled nursing unit volumes have declined in the last few years much like the entire volume of PRMC. According to the applicant, the primary force driving this decline in the skilled nursing volume is the growth and condition of the hospital facility. It would be expected that given the growth in the senior population, the facility's utilization would grow as well. Improving ADA-compliance with larger rooms, private showers and bathrooms, enlarged doorways for walkers and wheelchairs will provide an environment more conducive to attracting a large number of patients.

The estimated 65+ population for the 15 county service area is projected to increase from 206,202 in 2014 to 233,542 in 2018, and increase of 13.3%.

The applicant expects building a new facility to stop the decline in patient volume due to physician attrition by providing them with a competitive facility to serve their patients and is actively recruiting new physicians in various specialties, some of which have been recruited or are part of 2014 and 2015 recruitment plans.

The applicant projects 742 admissions and 7,383 patient days in year one, and 767 admissions and 7,630 patient days in year two of the project.

TENNCARE/MEDICARE ACCESS:
The applicant participates in the Medicare and TennCare programs. PMRC has TennCare MCO contracts with Blue Cross/Blue Shield, TennCare Select, and AmeriChoice.

The estimated first year Medicare/Managed Care gross revenues are $5,437,139 or 51% of total gross revenues and TennCare/Medicaid of $319,832 or 3% of total gross revenues.

ECONOMIC FACTORS/FINANCIAL FEASIBILITY:

The Department of Health, Division of Policy, Planning, and Assessment has reviewed the Project Costs Chart, the Historical Data Chart, and the Projected Data Chart to determine if they are mathematically accurate and the projections are based on the applicant's anticipated level of utilization. The location of these charts may be found in the following specific locations in the Certificate of Need Application or the Supplemental material:

Project Costs Chart: The Project Costs Chart is located on page 34 of the application. The total project cost is estimated to be $6,454,796.

Historical Data Chart: The Historical Data Chart is located on page 37 of the application. The applicant reports net operating income of $1,742,725, $3,250,060, and $3,063,415 in years 2011, 2012, and 2013, respectively.

Projected Data Chart: The Projected Data Chart is located in Supplemental 1. The applicant projects 742 admissions in year one and 762 admissions in year two with net operating revenues of $3,101,998 and $3,205,257.

The applicant's projected average gross charge is $14,368, with an average deduction of $6,471, resulting in an average net charge of $7,897.

The applicant considered the following three alternatives to this project; 1) Maintain the status quo, 2) renovation of the existing campus, 3) expansion of one of the hospital's other metro Knoxville hospital campuses. This replacement project was selected as a means of stopping rapid declines in utilization for physicians and patients, improving efficiencies and access, and employing the capital strategy with the best chance of a successful return.

CONTRIBUTION TO THE ORDERLY DEVELOPMENT OF HEALTHCARE:

The applicant provides a listing of all contractual and working relationships on page 45 of the application.

The applicant believes providing access to state-of-the-art, efficient, and accessible health care services will have a beneficial effect on the healthcare system. Additionally, ensuring the long-term viability of a tertiary care hospital in the service area will be beneficial to the overall healthcare system.

There will be no duplication of services that are already in place, right sizes them to the current demand and replaces them in a more efficient facility that is easier to navigate and less costly for the hospital to operate.

The current projected staffing for the skilled nursing unit is 8.0 FTE registered nurses, 5.0 FTE licensed practical nurses, and 7.0 FTE certified nursing assistants.

PRMC provides a listing of all the health care training/educational/relationships they have on page 47-48 of the application.

PRMC is licensed by the Tennessee Department of Health, Board for Licensing Healthcare Facilities and accredited by The Joint Commission. The most recent survey was conducted on 11/14/2013. Attachment C, Orderly Development, 7d contains the 22-page deficiency survey and plan of correction.

There is a judgment against the previous owner, Mercy Health System, which is under appeal.

SPECIFIC CRITERIA FOR CERTIFICATE OF NEED

The applicant responded to all relevant specific criteria for Certificate of Need as set forth in the document *Tennessee's State Health Plan.*

CONSTRUCTION, RENOVATION, EXPANSION, AND REPLACEMENT OF HEALTH CARE INSTITUTIONS

1. Any project that includes the addition of beds, services, or medical equipment will be reviewed under the standards for those specific activities.

   This criterion is not applicable.

2. For relocation or replacement of an existing licensed health care institution:

   a. The applicant should provide plans which include costs for both renovation and relocation, demonstrating the strengths and weaknesses of each alternative.

      The estimated investment to stay in the facility is $262,000,000 and there would be still be the inherent inefficiencies for staff and accessibility issues for patients. This is not a sound investment relative to investing $303,545,204 for a new facility in a new location that is more desirable than the current location.

      The applicant considered the following three alternatives to this project; 1) Maintain the status quo, 2) renovation of the existing campus, 3) expansion of one of the hospital's other metro Knoxville hospital campuses. This replacement project was selected as a means of stopping rapid declines in utilization for physicians and patients, improving efficiencies and access, and employing the capital strategy with the best chance of a successful return.

   b. The applicant should demonstrate that there is an acceptable existing or projected future demand for the proposed project.

      It would be expected that given the growth in the senior population, the facility's utilization would grow as well. Improving ADA-compliance with larger rooms, private showers and bathrooms, enlarged doorways for walkers and wheelchairs will provide an environment more conducive to attracting a large number of patients.

      The estimated 65+ population for the 15 county service area is projected to increase from 206,202 in 2014 to 233,542 in 2018, and increase of 13.3%.

3. For renovation or expansions of an existing licensed health care institution:

   a. The applicant should demonstrate that there is an acceptable existing demand for the proposed project.

   b. The applicant should demonstrate that the existing physical plant's condition warrants major renovation or expansion.

      This criterion is not applicable.